DOCUMENT RESUME

ED 173 495	UD 019 575
TITLE	Alcohol Abuse Training Relevant to Minority Populations. Trainer Manual, Trainee Handbook.
INSTITUTION	Southern Area Alcohol and Education Training Program, Inc., Atlanta, Ga.
SPONS AGENCY	National Inst. on Alcohol Abuse and Alcoholism (DHEW/PHS), Rockville, Md.
PUB DATE	77
GRANT	3-t21-AA00161-01
NOTE	102p.; For related documents, see UD 019 572-574; Not available in hard copy due to author's restriction ; Parts may be marginally legible due to small print
AVAILABLE FROM	Southern Area Alcohol Education and Training Program, Inc., 4875 Powers Ferry Road, N.W., Atlanta, Georgia 30327 ($20.00)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Alcohol Education; *Alcoholism; *Counselor Training; *Cross Cultural Training; Health Programs; *Minority Groups; Prevention; *Program Development; *Rehabilitation Programs; Sociocultural Patterns; Sociopsychological Services

ABSTRACT

This training manual presents current information about alcohol abuse and alcoholism among minority populations. It is designed to aid counselors employed in alcohol abuse programs. Areas discussed in this report include: interpersonal communication, knowledge of alcohol abuse and alcoholism, evaluation and assessment, planning, referral, counseling and treatment. Specific topics addressed include physiological, psychological, and sociological/anthropological approaches to alcoholism, resources, public relations, vocational rehabilitation, legal aspects, instructional planning research, and funding resources. Strategies for training counselors and implementing treatment and/or prevention programs which are relevant to the needs of minority group alcoholics and alcohol abusers are also outlined. (Author/EB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED173495

ALCOHOL ABUSE TRAINING
RELEVANT TO MINORITY POPULATIONS

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
Southern Area Alcohol
Ed. & Training Program
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Developed for

A Special Training Grant

From: Southern Area Alcohol Education and Training Program, Inc.

By: Memphis State University
College of Education
Department of Special Education and Rehabilitation

Dr. Thomas L. Porter
Project Director

Dr. Griff Long
Project Coordinator

Barbara Jones, M.Ed.
Assistant Project Coordinator

Patti Smith, M.Ed.
Assistant Project Coordinator

Funded Through: National Institute on Alcohol Abuse and Alcoholism

Distributed By:

SAAETP, INC.
4875 Powers Ferry Rd., N.W.
Atlanta, Georgia 30327

formation Center
2210

UD019575

© Copyright 1977 by the Southern Area Alcohol Education and Training Program, Inc.

All rights are reserved. No part of this material may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopied, recorded, taped, or otherwise, without prior written permission by the publisher. Clearance requests should be made in writing and sent to the attention of the Permission Department,

SAAETP, INC.
4875 Powers Ferry Rd., N.W.
Atlanta, Georgia 30327

This project is supported by Grant No. 3-t21-AA 00161-01, awarded by the National Institute on Alcohol Abuse and Alcoholism, DHEW. Opinions expressed and conclusions drawn in this publication do not necessarily represent the opinions of the Southern Area Alcohol Education and Training Program, Inc. or the National Institute on Alcohol Abuse and Alcoholism.

PREFACE

The Southern Area Alcohol Education Training Program, Inc., awarded a training grant for 1976 to Memphis State University, Department of Special Education and Rehabilitation funded through the National Institute on Alcohol Abuse and Alcoholism. The purpose of the training grant is to provide training skills to individuals employed in alcohol abuse programs for the thirteen Southeastern and Southwestern states, who in turn will provide training in the alcohol abuse needs of minority populations to concerned caregivers, interested citizenry, and individuals from other helping professions.

Specific objectives of the Memphis State project included: 1) conduct a five-day workshop for three classes of 15 trainees per class; (2) supervise the trainees with on-site visits when they are conducting their own area training program; (3) provide a 2½ day follow-up for each class after the participants have completed their training assignments; (4) develop a handbook from the best projects during the training project; and (5) research materials on minority populations and alcohol abuse in development of a training manual.

Approach to the Training Manual

After considering the above objectives concerning alcohol abuse and alcoholism, minority populations, and instructional planning, the staff began to search for information and materials related to these objectives. From these materials the staff developed a comprehensive training manual which can be used during the five-day workshop and by trainees when they conduct their on-site training program.

It was decided by the staff to research the basic content areas of a report prepared by Roy Littlejohn Associates, Incorporated, for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and to relate these areas to minority populations. The competency areas are: interpersonal communication, knowledge of alcohol abuse and alcoholism, evaluation and assessment, planning, referral, counseling and treatment. Other additional areas included in the manual are: physiological approach, psychological approach, sociological/anthropological approach, resources, public relations, vocational rehabilitation, legal aspects, instructional planning research, and funding resources.

The editing staff is deeply grateful to the Memphis State staff who devoted time and effort in contributing to both the presentations of content areas of the five-day workshop and development of the training manual: Drs. Tom Collins and Billye Fogelman, Department of Anthropology; Dr. Bill Brotherton, Continuing Education; Dr. David Anspaugh, Department of Health and Physical Education; Dr. Paul Schwartz, School of Social Work; Drs. George Noblit and Gail Thomas, Department of Sociology; Drs. Wilson Dietrich, Robert Greer, Brick Johnson, Al Quick, Department of Special Education and Rehabilitation. From the staff of the Tennessee Psychiatric Hospital and Institute; Drs. James Beard, David Knott, and Mrs. Peggy Moore; and to Gerald Overton of the Employee Assistance Program in the greater Memphis area.

In addition to the Memphis State staff, and Tennessee Psychiatric Hospital staff, special thanks to the staff of Southern Area Alcohol Education Training Program for their

timely remarks and suggestions in review of the trainer's manual. They are: Ed Alderette, Director; Suellen L. Martin, Associate Director; Marion Kiley, project Coordinator; and Gregory Berns, Coordinator for Evaluation and Research.

We deeply appreciate the time and efforts of Carolyn Banks, Project Secretary; Gretta Long; Stenographic Services — Sidney B. Daniel, supervisor; Laura Jean Glise; Lynne Smith; Donna Prysock; Gloria Benson; Normal Walker; Eddie Bousson; Lee Andrews; Gina Cook and Bob Costello.

Thomas L. Porter, Ph.D.
Project Director

Griff Long, Ed.D.
Project Coordinator

Barbara Jones, M.Ed.
Assistant Project Coordinator

Patti Smith, M.Ed.
Assistant Project Coordinator

DEDICATION

Leonard Melvin Lee

Born: June 29, 1935
Died: October 23, 1976

This manual is dedicated to the memory of Leonard Melvin Lee, one of the Class B participants who passed away recently. At the time of his death he was serving as director of the Alcoholism program of the Total Community Action, Inc. agency in New Orleans, Louisiana.

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION 9

Purposes and Objectives
Definitions of Alcoholism and the Alcoholic
Classification of the Alcoholic
Scope of the Problem
Legislative and Legal Factors
Role of Alcohol Rehabilitation Agencies

CHAPTER II. PHYSIOLOGICAL FACTORS 13

Short-Term Effects
Long-Term Effects
Causative Factors
Diagnosis
Treatment
Some Effects of Alcohol on the Body

CHAPTER III. PSYCHOLOGICAL APPROACHES 24

Pyschological Factors
Treatment Strategies
  Strategy I: Transactional Analysis
  Strategy II: Behavior Modifications
  Strategy III: Psychodrama — A Model for Role Change
  Strategy IV: Gestalt Therapy
  Strategy V: Treatment Through the Group
  Strategy VI: Interpersonal Communication Skills
  Strategy VII: Family Therapy
Summary of Requirements, Interventions, and Relationships of Therapy
Conclusions

CHAPTER IV. SOCIOLOGICAL/ANTHROPOLOGICAL APPROACH 39

Supercultural
Sub-Structural
Specific Cultures
Anthropological Approach

CHAPTER V. ALCOHOL ABUSE CONCERNS AND NEEDS OF MINORITY POPULATIONS 43

Minority Populations
Demographic Characteristics
Unique Needs and Concerns
Treatment Program for Minority Populations
Preventive Measures
Research Findings

CHAPTER VI. REVIEW OF RESOURCES 53

- Community Resources
- Books
- Periodicals
- Dissertations/Unpublished Materials
- Project Reports/Manuals
- Films
- Films for Loan
- Organizations

CHAPTER VII. PUBLIC RELATIONS 61

- Tools of Communication

CHAPTER VIII. VOCATIONAL REHABILITATION 66

- Evaluation
- Tools Used in Evaluation or Assessment
- Planning
- Referral Process
- Job Placement and Follow-Up
- Employee Assistance Program
- Cooperation During the Rehabilitation Process
- Responsibility of Supervisors

CHAPTER IX. LEGAL ASPECTS 76

- Historical Perspective
- Legislation
- Government and Legal Controls

CHAPTER X: INSTRUCTIONAL PLANNING 81

- Competency-based Instruction
- Writing Clear Objectives
- Curriculum Design
- Evaluation and Feedback
- Module Construction
- Effective Utilization of Audio Visual Materials
- Recommendations for Alcohol Abuse Prevention Materials
- Array or Assortment of Questions for Pre- and Post-Tests

CHAPTER XI. FUNDING FOR ALCOHOL PROGRAMS 97

- Local Community
- State Alcoholism Agencies (SAA)
- Regional Offices
- National Institute on Alcohol Abuse and Alcoholism Regional Offices
- Area Alcohol Education and Training Programs, Incorporated
- NIAAA (National Institute on Alcohol Abuse and Alcoholism)
- Considerations When Applying

Chapter I

INTRODUCTION

This chapter is divided into the following sections: Purpose and Objectives; Definitions of Alcoholism and the Alcoholic; Classification of the Alcoholic; Scope of the Problem; Legacy of the Alcohol Problem Movements; and Role of Alcohol Rehabilitation Agencies.

Purpose and Objectives

The purpose of this training manual is to assimilate current information concerning alcohol abuse and alcoholism among minority populations in order that individuals employed in alcohol abuse programs may train others in the needs and concerns of minority populations regarding alcohol abuse and alcoholism. For the purposes of this manual, minority populations are defined as those groups that receive unequal services and possess unequal power, regardless of number.

More specifically, the editors were interested in obtaining relevant information in the following areas:

(1) Definition, classification, and scope of the problem of alcohol abuse
(2) Physiological approaches to alcoholism
(3) Psychological approaches to alcoholism
(4) Sociological/anthropological approaches to alcoholism
(5) Alcohol abuse concerns and needs of minority populations
(6) Review of resources
(7) Public relations
(8) Vocational rehabilitation
(9) Legal aspects of alcohol abuse
(10) Instructional planning
(11) Effective research

Definitions of Alcoholism and the Alcoholic

There are presently a myriad of definitions of "alcoholism" and "alcoholic." Definitions of alcoholism are usually associated with a particular theory of its etiology, and give more attention to one kind of symptom than others, e.g., physiological factors over psychological or sociological factors. The various definitions of alcoholism have two elements in common: (1) drinking, and (2) some type of physiological, psychological, or sociological damage caused by drinking. The various definitions reflect the ongoing controversy over whether alcoholism is a symptom or a disease and it appears that no one definition is completely satisfactory.

One psychiatrically-oriented definition which combines descriptive criteria with a suggestion concerning the origins of alcoholism is that of Drs. Morris Chafetz and Harold Demone:

> We define alcoholism as a chronic behavioral disorder which is manifested by undue preoccupation with alcohol to the detriment of physical and mental health, by a loss of control when drinking has begun (although it may not be carried to the point of intoxication) and by a self-destructive attitude in dealing with personal relationships and life situations. Alcoholism, we believe, is the result of disturbance and deprivation in early infantile experience and related alterations in basic physiochemical responsiveness; the identification of the alcoholic with significant figures who deal with life problems through the excessive use of alcohol; and a sociocultural milieu which causes ambivalence, conflict, and guilt in the use of alcohol.

The most widely used and generally accepted definition of the alcoholic is the one given by the World Health Organization:

> *Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments. They therefore require treatment.*

Classification of the Alcoholic

The nature and patterns of alcohol use are varied and diverse. A workable classification system was first developed in 1960 by E.M. Jellinek in *The Disease Concept of Alcoholism.* Since that time further classification systems have been developed and refined. However, the most widely used classification system in this decade is still that ascribed to Jellinek, who discusses "alcoholisms" rather than "alcoholism." They are as follows:

Alpha Alcoholism refers to a psychological continued dependence on alcohol to relieve physical and psychic pain. This type of dependence is characterized by the use of alcohol at inappropriate times and places, but is not characterized by loss of control or inability to abstain. Alpha alcoholism is similar to what some call "symptomatic alcoholism."

Beta Alcoholism is a type of alcoholism in which severe medical complications occur such as gastritis, polyneurology, and cirrhosis of the liver. There is neither physical nor psychological dependence and no withdrawal symptoms are manifested.

Gamma Alcoholism is characterized by psychological dependence, tissue tolerance, loss of control, and withdrawal symptoms. This particular species constitutes a disease in and of itself and is considered the most prevalent type in the United States producing the most serious kind of damage.

Delta Alcoholism shows characteristics similar to Gamma Alcoholism but instead of a loss of control, there is an inability to abstain from drinking.

Epsilon Alcoholism is a periodic type of alcoholism which is often obscure and manifested by "binges" which are preceded by depression or mania or associated with the individual's emotional or physical health and with environmental and social factors.

Jellinek (1960) also speaks of alcoholics in terms of belonging to two main groups of *addictive* and *nonaddictive alcoholics.* Addictive alcoholics are those who are psychologically and physically dependent on alcohol. This type manifests a loss of control and is the type of alcoholic generally found in Alcoholics Anonymous (AA). The nonaddictive alcoholic is similar to the addictive but there is no physical dependence on alcohol and, thus, loss of control is not a feature.

Through the above classification system, Jellinek derives a simple operational definition of alcoholism as "any use of alcoholic beverages that causes damage to the individual or society, or both." This definition is simple and understandable, but not specific enough unless used with his classification system.

Scope of the Problem

According to the Department of Health, Education and Welfare, alcoholism stands third in public health problems in the United States, preceded only by heart disease and cancer. Current data indicate that between nine and ten million American individuals are alcoholics. If we couple this estimate with the fact that each alcoholic directly affects four or five other persons among his family, close friends, employers and employees, peer groups and so on, then the estimate of the number of people directly affected by the problem of alcoholism rises to 40 or 50 million.

The effects of alcoholism are seen not only in loss of human potential, but also in the loss of economic goods and services. According to Bell (1970), alcoholism is costing American industry over 7.5 billion dollars annually.

A current review of literature on alcoholism also reveals that approximately one-fifth of the inmates in federal and state penitentiaries as well as one-third of all admissions to state-supported psychiatric hospitals are considered to be alcoholics. At least one-fourth of suicides and homicides are committed by alcoholics.

Compounding this monumental health problem is the fact that very few physicians have the necessary knowledge and training in the areas of alcoholism. Medical schools report that the study of alcoholism receives little emphasis in the curriculum, if any. This lack of knowledge and training unfortunately is applicable to other segments of society: parents, relatives, friends, behavioral scientists, as well as the alcoholic himself. The situation is changing and the traditionally abandoned alcoholic is gradually being acknowledged, treated and rehabilitated, but the change is taking place much too slowly.

Legislative and Legal Factors

[A brief summary of the legal aspects follows, but for a more comprehensive viewpoint see Chapter VII, "Legal Aspects of Alcoholism."]

The American society has always had ambivalent feelings about alcohol in its culture from its earliest Protestant beginnings. The division in Protestantism over alcohol, between fundamentalist and liberal branches, has only deepened that ambivalence. One positive consequence of the recent movement to rehabilitate the alcoholic seems to be a gradually spreading change in the definition of the alcoholic from a "sinner" or "deviant," to a sick person or an individual with a disease.

Both the anti-alcohol and the anti-alcoholism movements have had an extensive and long-lasting effect upon American society on at least three levels: a general level, a normative level, and a legal level. Culturally, the anti-alcohol movement provided us with one of the most colorful and exciting eras in American history — prohibition. From this era came a new argot: "Demon Rum," "bathtub gin," "King Alcohol," "The Speakeasy," "bootlegger," and "Wet and Dry," and slogans such as the WCTU's "Lips that have touched liquor shall never touch mine" have become part of American folklore. The intended goal of the anti-alcohol movement was to eliminate drinking; however, its actual effect was that it changed the type and place of drinking. During prohibition there was an increase in the number of females who would now drink in "public." The anti-alcoholism movement, on the other hand, has really not, as of yet, contributed substantially to the general culture context of American society (Mauss, 1975).

On the normative level, too, the anti-alcohol movement has had a considerable impact. Through the termperance movement, new values, attitudes, and behavior patterns emerged and became ingrained in the American way of life. The anti-alcoholism movement also affected the normative structure of American society. The recovering alcoholic began to show society that he can change and can lead a full and productive life without alcohol. The public is now beginning to realize that the alcoholic is different from other people, not in a moral sense, but in a medical sense. The role of the recovering alcoholic has become for many a role of helper, therapist, or rescuer of others caught up in the problem of alcoholism.

Both movements have had an impact on society on the legal level. Through various organizations and groups which promoted its goals, the anti-alcohol movement was very successful in establishing legal principles which brought about sweeping changes in the legal treatment of alcoholics. The most notable was the 18th Amendment and its accompanying enforcement law, the Volstead Act. One of the breakthroughs in the legal pattern was the case of *Driver v. Hinnant, 1966*. The U.S. Court of Appeals for the fourth circuit ruled that Driver was a chronic alcoholic and that to convict him of public drunkeness was "cruel and unusual punishment." According to the 18th Amendment, he was suffering from the disease of alcoholism, and his acts were symptomatic of that disease (Mauss, 1975).

The anti-alcoholism movement has also been a motivating force behind changes and new developments on the federal level related to the problem of alcoholism in the United States. It was not until 1966, when President Lyndon Johnson established the National Center for the Prevention and Treatment of Alcoholism, that alcoholism was viewed as distinct from alcohol use. In 1970, primarily due to the efforts of Senator Harold Hughes, a recovering alcoholic, the Comprehensive Alcohol Abuse and Alcoholism Act was passed. This act included the establishment of a federal alcoholism program, the formation of the National Institute of Alcohol Abuse and Alcoholism, and the appropriation of about $300,000,000 to be used over a three-year period for the development and confirmation of alcoholism treatment and prevention programs (Mann, 1973).

Role of Alcohol Rehabilitation Agencies

Traditionally, alcoholism has been a perplexing phenomenon to both the medical and non-medical communities in spite of its catastrophic impact of society. Few other national health problems, if any, have been surrounded by the kind of public and professional antagonism, ambivalence, apathy, and ignorance that surround the problem of alcoholism.

Efforts in rehabilitation have been limited, possibly due to the unexplainable quality of alcoholism and, perhaps, more importantly, to societal indignation and non-acceptance of alcoholism as a disease. Within the past two decades, the nature and extent of the problem has been recognized but action in response to this recognition has been mainly clinical and legal in nature with the clinical services placing little emphasis on prevention and control through rehabilitation.

Research data strongly support the conclusion that placing alcoholics in jail does not decrease the number of arrests for public intoxication. Rehabilitation referral and use of community resources outside the criminal justice system on the other hand have been shown to be effective methods of reducing the frequency of chronic intoxication offenders, and the allocation of financial resources to rehabilitation services has been demonstrated to be a sound economic step when compared to those monies spent on repeated arrests, arraignments, and incarcerations of offenders.

Cull and Hardy (1974) in discussing the role of rehabilitation agencies and the alcoholic suggest that while the implementation of direct services and the improvement of treatment modalities are of utmost and primary importance in an agency offering services to the alcoholic, a special priority should be given to the development of a cost-accounting system in order to strengthen and increase public support. Thus, if treatment is to be available and adequate, an important and necessary role of the agency must be to prepare and educate the community.

The primary goals of rehabilitation agencies may be viewed as follows: (1) preparation and education of the community in order to facilitate available and adequate treatment resources; (2) participation in a cooperative effort with both medical and non-medical individuals for the purpose of developing a treatment program directed toward the alcoholic as an individual, which includes a sound knowledge of his cultural milieu; (3) provision for a multiplicity of services including marital, group, individual, and conjoint therapy, vocational exploration, training, and job placement when appropriate; and (4) adequate follow-up and supportive efforts over an extended period of time.

References

Bell, R.G. *Escape from addiction*. New York: McGraw-Hill, 1970.

Chafetz, M. and Demune, H. "Program to control alcoholism." In Caplan, D. ed., *American Handbook of Psychiatry* (in press).

Cull, J.G. and Hardy, R.E. *Organization and administration of drug abuse treatment programs.* Springfield, Illinois: Charles C. Thomas, Publishers, 1975.

Jellinek, E.M. *The disease concept of Alcoholism.* New Haven: Hillhouse Press, 1960.

Mann, M. America's 150 year war: alcohol vs. alcoholism. *Alcohol Health and Research World*, 1973, *1*, 5-7.

Mauss, A.L. *Social problems as social movements.* Philadelphia: J.B. Lippincott Company, 1975.

Tracy, D. *What you should know about alcoholism.* New York: Dodd, Mead, and Company, 1975.

World Health Organization, Expert Committee on Addiction-Producing Drugs. Sixth Report, 1955.

Chapter II

Physiological Factors

(The basic information for this section came directly from the booklet *Alcohol & Alcoholism*, DHEW Publication No. (HSM) 72-9127 prepared by National Institute on Alcohol Abuse and Alcoholism, Division of National Institute of Mental Health, Revised 1972.)

Since the beginnings of written history there has been evidence of the existence of intoxicating beverages, both wines and stronger drinks, and their effects were well known within ancient cultures. The Egyptians credit Osiris, and the Greeks Bacchus (or Dionysus), with introducing wine, while Noah is the reputed wine-bringer of the Hebrews (Grossman, 1964).

The first face of alcohol is the positive face. Alcohol in one form or another was probably the first tranquilizer known to human beings. It is a food, since it is a source of calories, although as nourishment it is imperfect, having no vitamins. It is a drug, since it acts upon the central nervous system. Alcoholic beverages are now being used by some physicians in the diets of diabetic patients, since alcohol, unlike sugar, does not require insuiin for metabolism (Leake & Silverman, 1966).

Unfortunately it is the naure of man and alcohol that such beverages are often not well used. Thus, the second face of alcohol, the mask of tragedy, is seen far too frequently, in the anguished expression of the alcoholic patient undergoing the pains of withdrawal, for example, or the disbelieving horror of the drinking driver confronting his accidental victim.

Given the long history of men and alcohol, there has developed a fund of folklore and folk wisdom. Like most folk observations, the lore of drinking mixes fact with fiction. For example, many people believe that if they must drive after drinking, coffee will speed the sobering-up process. This is not true. Coffee can keep people awake but it cannot improve judgment or sharpen reactions dulled by alcohol. The person who expects to drive after drinking should either pace his intake, or wait until his liver is able to burn up the alcohol. It is now known that the average person should allow one hour of every half ounce of alcohol consumed. Knowledge regarding the effects of alcohol, both short-term and long-term, is essential to the person who wants to drink responsibly.

Short-Term Effects

Alcoholic beverages are such a familiar part of our life style that it is hard to realize that alcohol is a drug. Its primary effects are in the central nervous system, although the whole body is affected.

Stimulant

Alcohol is often thought of as a stimulant because it appears to make people more lively and uninhibited. In very low concentrations, it does stimulate cellular activity in most organisms from the simplest bacteria to the most complex mammals. In moderate quantities, alcoholic beverages slightly increase the heart rate; slightly dilate blood vessels, in arms, legs, and skin; moderately lower blood pressure; stimulate appetite; increase production of gastric secretion; and markedly stimulate urine output. In higher concentrations alcohol can depress function, seriously injuring cells, or even killing them (Leake & Silverman, 1966).

Depressant

Alcohol is technically considered to be a depressant, since it primarily depresses functions of the central nervous system. The reactions are not necessarily related to the amount of alcohol drunk, but to its concentration in the blood. Alcohol, unlike most other foods, does not have to be digested slowly before reaching the blood stream. It is immediately absorbed into the blood, passing directly through the walls of the stomach and small intestine. The blood rapidly carries it to the brain. When the blood alcohol levels are low, their effect is usually mild sedation, relaxation, or tranquility. Slightly higher levels, at least in some people, may produce behavioral changes which seem to suggest stimulation of the brain; the person becomes talkative, aggressive, and excessively active. However, these changes are thought to result from depression of the most highly developed brain centers which normally inhibit or restrain such behavior. At still higher levels, great depression of lower parts of the brain occurs, producing lack of coordination, confusion, disorientation, stupor, anesthesia, coma, or death

The following chart shows the general relation between blood alcohol levels and behavior for a 155-pound moderate drinker who rapidly consumes 90-proof whiskey on an empty stomach. These levels might be slightly higher if the drink is vodka or gin, or if the person weighs much less than 155 pounds. Conversely, the level will be lower if the beverage is beer, wine, or a "mixed" non-carbonated drink; if the drink is taken with solid foods; or if the drinking is spaced over a prolonged period.

Quantity	*Percent Blood alcohol level*	*Resulting Behavior*
3 oz. whiskey (2 shots)	0.05	Sedation & tranquility accepted level of beginning impairment
6 oz. whiskey	0.10	lack of coordination Legal intoxication in most states
12 ox. whiskey	0.20	Obvious intoxication
15 oz. whiskey	0.30	Unconsciousness
30 oz. whiskey	0.50+	Death may result

Blood Levels

There are important legal implicatons concerning blood levels. A person with a 0.15 percent or less blood-alcohol level in most parts of the United States is legally presumed to be sober and in condition to operate a motor vehicle, while 0.10 percent or more constitutes legal intoxication in some states. It is still uncertain whether there is a threshhold below which alcohol has no detectable influence on reflex responses, reaction time, and various complex skills. However, when blood-alcohol level reaches 0.03 or 0.05 percent, it is generally agreed that changes are evident. Some studies have shown that the effects of alcohol on skilled performance are not necessarily related simply to alcohol concentration in the blood. The studies indicate that skilled performance may be impaired at a certain level when the blood-alcohol curve is rising, but there may be no impairment at the very same level when the blood-alcohol curve is falling. (Goldberg, 1970).

Factors Related to Absorption and Behavioral Effects

The rate at which alcohol is absorbed into the bloodstream and its behavioral effects are influenced by a number of interactional factors:

1. *Speed of drinking.* The more rapidly an alcoholic beverage is ingested, the higher will be the peak blood level concentrations.
2. *Body weight.* The greater the weight of body muscle of the individual the lower his blood alcohol concentration resulting from a given amount of alcohol.
3. *Presence of food in the stomach.* Eating while drinking noticeably retards the absorption of alcohol.
4. *Drinking history and body chemistry.* Each person has an individual pattern of physiological function which may affect his reactions to alcohol. The "dumping syndrome" occurs when the stomach empties more rapidly than normal, and alcohol seems to be absorbed more quickly. Emptying time may be either slowed or speeded by anger, fear,

stress, nausea, and the condition of the stomach tissues. In individuals with a long history of drinking, tolerance to alcohol develops, so that an increased dosage must be used to give effects similar to those obtained with the original dose. (In individuals with serious drinking problems, the curve of tolerance is reversed, and again they are very responsive to relatively small amounts of alcohol.)

5. *Types of beverage*. The chief ingredient in all alcoholic beverages — beer, table wine, cocktail or dessert wines, liqueurs or cordials, and distilled spirits — is ethyl alcohol, known also as ethanol or fermenting sugar with yeast spores. The concentration of alcohol is usually:

Percent	*Beverage*
4	American beers
10-12	Table wines
17-20	Cocktails, dessert wines, sherries
22-50	Liqueurs
40-50 (80-100 proof)	Distilled spirits

In addition, these beverages contain a variety of other chemical constituents. These non-alcoholic "congeners" contribute in their own right to the effects of certain beverages, either directly affecting the body, or affecting the rates at which alcohol is absorbed into the blood and is oxidized or metabolized in the tissues.

Metabolism

The speed of alcohol absorption generally affects the rate at which one becomes intoxicated, while the speed of alcohol metabolism affects the rate at which one becomes sober again. Once absorbed into the bloodstream and distributed throughout the body, alcohol undergoes metabolic or oxidative changes. A major part of these processes occurs in the liver. The total metabolic process yields about seven calories of energy for each gram (0.353 fluid ounces) of alcohol. Almost all of the ingested alcohol is metabolized by the liver; however, two to five percent is excreted chemically unchanged, mostly in urine, breath and sweat. Normal drinkers can metabolize an average of seven grams per hour of pure alcohol; eight grams in the form of whiskey; nine grams in the form of beer. A rule of thumb is that it will take as many hours as the number of drinks consumed to sober up completely and drinking coffee, taking a cold shower, or breathing pure oxygen will not hasten the process.

Hangover

The familiar after-effect of over-indulgence is the hangover — the morning-after misery of extreme fatigue combined with nausea, upset stomach, anxiety, and headache. The symptoms are usually most severe many hours after the peak of the drinking bout when little or no alcohol can be detected in the body. There is insufficient evidence to attribute the hangover to mixing drinks, vitamin deficiencies, dehydration, fusel oils (non-alcoholic components of alcoholic beverages which are relatively toxic, but present in clinically insignificant amounts), or any other non-alcoholic components. Additionally, there is no scientific evidence to support the curative claims of popular remedies such as coffee, raw egg, oysters, chili peppers, steak sauce, "alkalizers," vitamin preparations, "the hair-of-the-dog," or such drugs as barbiturates, amphetamines, or insulin. Doctors usually prescribe aspirin, bed rest, and solid food as soon as possible.

Long-Term Effects

Drinking alcohol in moderation apparently does the body little permanent harm. But when taken in large doses, over long periods of time, alcohol can prove disastrous, impairing both the quality and the length of life. Structural damage to several major organs may result.

Heart

An essential muscle affected by alcohol is that of the heart; the myocardium. Alcohol can produce heart disease without the presence of liver impairment. Alcohol, through various studies, has been found directly toxic to both the heart and lungs. In some men and women, the toxic effects of alcohol on the cardiovascular system are so great that fatal cardiac arrest can result from excessive intakes (Medical World News, 1971).

Digestive Tract

When large quantities of alcohol are consumed, especially "straight," the gastrointestinal system can become irritated. Nausea, vomiting, and/or diarrhea are mild indications of trouble. The more frequently such ingestion takes place, the greater the irritation. Gastritis, ulcers, and pancreatitis commonly occur among alcoholic individuals.

Liver

Liver damage may also result from heavy drinking, although it is not certain precisely how alcohol affects the liver. Cirrohsis (hardening) of the liver occurs about six times as frequently among alcoholics as non-alcoholics (Lieber & Davidson, 1962).

Infectious Diseases

Very heavy drinkers have long been known to have lowered resistance to pneumonia and other infectious diseases. Malnutrition is usually considered to be the cause. A study conducted at Cornell University showed that with blood-alcohol levels of 0.15 to 0.25 percent, produced by intravenous administration of alcohol, the inhibition of white-blood-cell-mobilization was as intense as that found in states of severe shock.

Gout

Heavy drinking over many years may result in serious mental disorders or permanent, irreversible damage to the brain or peripheral nervous system. Critical mental functions such as memory, judgment, and learning ability can deteriorate severely, and an individual's personality structure and reality orientation may disintegrate as well. With serious brain damage in alcoholic persons, Korsakoff's syndrome may result. In this psychotic condition patients cannot remember recent events and compensate by making up fictitious events. Vitamin therapy is often used to treat polyneuritis and memory deficit.

Causative Factors

Considerable research has been devoted to trying to find physical factors, either in the alcohol itself, or in the biological make-up of those who drink, which could account for alcoholic drinking and addiction. However, neither chemicals in specific beverages nor physiological, nutritional, metabolic, or genetic defects have been found which could fully explain alcohol drinking.

Heredity

Alcoholism occurs frequently in children of alcoholics, and thus may seem to have some hereditary basis, yet it also occurs in children of devout abstainers. While some individuals may have genetic characteristics that pre-dispose them to problems with alcohol, for most individuals, alcohol problems are probably related more to other factors (Blacker, Demone, & Freeman, 1965).

Vitamin Deficiency

Vitamin deficiencies or hormone imbalances have also been suggested as causes of alcoholism. Most of the nutritional and hormonal deficiencies seen in individuals with advanced alcoholism, however, appear to be results rather than causes of excessive drinking (Mendelson & La Doub, 1964).

Metabolism

It has been said that alcoholic individuals are unable to metabolize alcohol as rapidly as normal individuals, although research indicates that many actually metabolize it about 10 to 20 percent more rapidly when they are drinking heavily. It has been suggested that continued drinking of alcohol might stimulate increased production of the enzymes necessary to metabolize alcohol (Mendelson & Stein, 1966).

Cortisone Production

Studies have revealed that alcoholic individuals with the greatest increase in cortisone production during heavy drinking periods also showed the greatest increase in the rate of alcohol metabolism. In these alcoholic individuals compared to normal individuals, cortisone production seemed to be part of a general reaction to alcohol consumption; it was associated with increased anxiety during the drinking period and perhaps with the later withdrawal symptoms.

Non-Alcoholic Components

Alcohol addiction is sometimes attributed to certain non-alcoholic components in beer, wine, whiskey, rum, and brandy. However, since alcoholism has been shown to occur in users of alcoholic beverages very low in these components (e.g. vodka), this hypothesis seems untenable (Leake & Silverman, 1966). It has been hypothesized that in alcoholic individuals, a defect in the metabolism of acetaldehyde (first step in the metabolic chain) produces substances in the body that are forerunners or precursors of opiate alkaloids. Thus, the body might be manufacturing its own addictive substances (Davis & Walsh, 1970).

Diagnosis

A general description of the variables involved in labeling a person as an alcoholic has been given in a report prepared for the cooperative Commission on the Study of Alcoholism:

1. *The quantity of alcohol consumed.* It is obvious that there is no alcoholism without alcohol, but quantity alone is an inadequate determinant.
2. *Rate of consumption.* One pint of hard liquor consumed during a ten-hour period causes a qualitatively different behavior pattern than the same amount consumed during a one-hour period.
3. *Frequency of drinking episodes.* A person who gets drunk three or four times a year is less likely to be labeled an alcoholic than someone who gets drunk every week.
4. *The effect of drunkenness upon self and others.* A man who commits deviant sex acts or beats his wife while drunk is more likely to be labeled an alcoholic than a man who quietly gets drunk and leaves others alone.
5. *Visibility to society's significant labeling agents.* The police, judiciary, school personnel, welfare personnel, rehabilitation personnel, employers, social peers, and helping agents (e.g. psychiatrists, physicians, psychotherapists, lawyers) are the key instruments of alcoholic labeling.
6. *The total social matrix.* There are different norms for different classes and status groups in the social system. Social context is a key determinant of whether a person will be labeled an alcoholic and therefore, be reacted to as an alcoholic (Cahn, 1970).

Treatment

Alcoholism is a treatable illness from which as many as two-thirds of its victims can recover. Research on therapeutic methods has revealed that there are a number of different clinical states which must be recognized and treated individually if an alcoholic patient is to receive appropriate care. These include:

1. Acute alcohol intoxication or severe drunkenness.
2. Alcohol withdrawal symptoms short of delirium tremens.
3. Delirium tremens (DT's).
4. Other psychiatric conditions associated with alcoholism, such as hallucinations.
5. Long-term problem of addiction.

Acute Alcohol Intoxication

In the treatment of acute alcohol intoxication, various tranquilizers are often used, and have been found extremely helpful in treating withdrawal symptoms — the tremulousness, anxiety, sleeplessness, nausea, and general discomfort which occur when an alcoholic person stops drinking. Among the tranquilizers used are chlorpromazine, hydrochloride, and chlordiazepoxide. The latter drug has been found particularly safe and effective in preventing delirium tremens and convulsions during withdrawal.

Alcohol Withdrawal Symptoms Short of Delirium Tremens

Here the major evaluative problem has been finding a suitable technique for measuring the value of the various treatments. Some investigators have sought to use the degree of tremor or shaking as an indication of the severity of the condition.

Delerium Tremens [DT's]

Delerium tremens is a serious and sometimes fatal condition in which chronic drinkers, often after withdrawal, are confused, trembling, fevered, and sometimes convulsive. They have terrifying hallucinations, usually of rats or snakes crawling on them. About five percent of alcoholics in hospitals and perhaps 20 to 25 percent of those who suffer the DT's alone and unattended die as a result. Suicide is sometimes the cause of death. Along with major tranquilizers, intensive nursing care and proper control of the patient's food intake and fluid electrolyte balance are important therapeutic aids. The phenomenon of delirium tremens is not simply a direct toxic effect of alcohol on the brain. In fact, it usually occurs after alcohol withdrawal in individuals who have been steadily consuming alcohol for many days or weeks, and who then stop drinking. Even less understood than delirium tremens is the phenomenon of alcohol hallucinosis — a more chronic condition, usually marked by auditory hallucinations, but without the disorientation and panic seen in delirium tremens.

Research Concerning Treatment

Investigators observed that some alcoholics brought to the emergency room at a Boston City Hospital in the state of a coma after ingesting large amounts of alcohol didn't have particularly high blood-alcohol levels but did have extremely low blood-sugar levels. The investigators concluded that a large dose of alcohol taken by an individual who has been fasting for 24 hours or more can produce a rapid, dramatic drop in blood-sugar concentrations and, in fact, can cause the so-called hypoglycemia similar to that produced by large doses of insulin. The alcohol, it seems, prevents the liver from manufacturing and releasing sugar into the bloodstream in the normal way, and the normal homeostatic mechanisms which protect the body from low blood-sugar levels — even during periods of starvation — stop functioning. By understanding the physiological basis for this type of coma, physicians can take appropriate measures to relieve the patient.

Another research finding had to do with dehydration. Patients during withdrawal are not dehydrated, and do not necessarily need intravenous fluids to correct their fluid electrolyte balance. In fact, over-hydration rather than dehydration is likely to be the problem, since alcoholic drinkers actually consume large amounts of other liquids while on a binge, often resulting in a positive water balance during withdrawal (Medical World News, 1971).

Long-Term Problem of Addiction

Most physicians use a pharmacological bridge over the difficult early days or weeks for patients starting long-range treatment. Many physicians commonly prescribe minor tranquilizers to produce relaxation and to reduce tensions, which many alcoholic persons believe to have triggered their drinking bouts. Other physicians use what is sometime called "conditioned-response" or "aversion" therapy — administering an alcoholic beverage and at the same time a powerful nausea-producing agent, like emetine or apomorphine, which is intended to develop a conditioned reflex — loathing alcohol of any form.

More widely known and used are the so-called "deterrent agents" such as disulfiram (Antabuse) and citrated calcium carbimide (Temposil). A patient regularly taking one of these compounds finds that if he drinks alcohol in any form, a pounding headache, flushing, nausea, vomiting, and other unpleasant symptoms will result (Fox, 1958). Antabuse is most effective with older, socially stable individuals with long drinking histories who are well-motivated and not depressed.

Some Effects of Alcohol on the Body

(This section is adapted from a presentation made to the 1976 training classes at Memphis

State University by Dr. James D. Beard, Director of the Alcohol Research Center at the Tennessee Psychiatric Hospital and Institute, Memphis, Tennessee.)

Although alcoholism is centuries old and involves millions of people, the fact remains that there is very little known about the drug, ethyl alcohol. Anyone who has been working in the area of alcoholism recognizes that the total concept of an alcoholic or alcoholism has been and still is completely enshrouded in medical ignorance, misunderstanding, and very obvious emotionalism. What I would like to do is present some current data concerning the effects of alcohol upon the body, regardless of the dietary intake, that will demythologize the drug, ethyl alcohol. Let us examine some of these myths.

Myth: All Alcoholics are Dehydrated

Since 1938, most alcoholics have been treated as if they were dehydrated. It was in 1938 that the mechanism of the alcohol-induced diuresis was elucidated. People had long recognized at least people who had consumed ethyl alcohol — that it did increase urine formation. A very important point has been completely overlooked, however.

The important point is that ethyl alcohol is a diuretic only as long as the blood alcohol level is increasing. It is dependent not only upon an increasing level but also upon the rate of rise of the blood alcohol concentration. Once the blood alcohol level has peaked and plateaued at a high or low level, or once it begins to fall, antidiuresis ensues. The type of diuresis is primarily pure water. We retain many of the body salts.

During the diuretic phase there is a marked retention of sodium, potassium, and chloride by the kidneys. The kidneys are excreting free water. One electrolyte that does not share in this retentive response is magnesium. There is an enhanced renal excretion of magnesium during the period of alcohol ingestion and indeed, in many patients, there can be a significant depletion in the total exchangeable amount of magnesium in the body from a drinking spree as short as three days.

It is fact that alcohol is a diuretic, but it is not fact that the presence of alcohol in the blood promotes a diuretic response. Because of the controversy in this area, fluid and electrolyte balance in the alcoholic patient must be examined. In investigating this problem we went first to the experimental laboratory, and suffice it to say that in the animal experiments that will be presented we have used differing doses of ethyl alcohol. In the study, we partitioned the total body water, the extracellular fluid volume, and the plasma volume in well-nourished dogs that were given an oral intoxicating dose of alcohol daily for two months. These measurements were made on a weekly basis at a time when there was no alcohol detectable in the blood, usually about 24 hours after the last dose and about 16 hours after the last meal.

Rather than dehydration, we found a significant and sustained increase in the total body water of these animals receiving alcohol daily. This increase was reflected in the extracellular fluid volume and in the plasma volume. Repeat these measurements, and you will find within five days that the total body water will be back in normal range just following abstinence from alcohol. During this period of time, if you collect the urine on a 24-hour basis, you will find that the urinary volume is increased because of the diuresis that has been brought about by ethyl alcohol. If you also measure the 24-hour fluid intake you will find that this has increased considerably more, and thus the animals end up in a positive water balance during the period of alcohol ingestion.

Going to the Alcoholic Rehabilitation Unit, the same measurements were made in a chronic alcoholic population. Let me point out that patients with edema on admission were not included in this study. These patients had at least a one-week drinking spree prior to admission and again there was no detectable amount of alcohol found in the blood at the time of measurements. Upon admission the total body water content was significantly elevated over that of a comparable control group. Again the increase was reflected in the extra-cellular fluid volume and in the plasma volume. By not using intravenous fluids, the patient's total body water was measured four days following the withdrawal of alcohol.

The values decreased to within the normal range for all of the measured fluid spaces. Even in this patient population composed of well-nourished middle-class type alcoholics, which obviously was not complicated by vomiting and/or diarrhea — we have uniformly found in about 94 percent of these cases over-hydration rather than dehydration. The increase in the total body water was isosmotic in nature.

Upon admission and four days following the withdrawal there was no change in the plasma sodium concentration. The same was true for potassium. One point to note is that the serum magnesium level was in the low normal range. Many physicians do not get concerned if they have a value in the low normal range. Many times it is forgotten that the plasma value is really the last to fall. At this particular time when we have a low serum magnesium or normal range of serum magnesium, if you use an isotope of magnesium and determine the total exchangeable amount in this patient population, you will find that there is a significant depletion of the total exchangeable magnesium. Take the alcohol away and we find this value comes back to normal when the patient is on the regular hospital diet. Also, it was found that there was no change in chloride concentration and no change in the osmolality of the plasma.

Of particular interest to us are the changes that occur within the red blood cell. We have found in the experimental lab changes in electrolytes in neural tissue, skeletal muscle, cardiac muscle, liver, the GI tract, etc. Upon admission there is more red-blood-cell sodium than is normally found, while the potassium is low. The potassium increases and the sodium decreases following the withdrawal of ethyl alcohol. We have found this both experimentally and in the clinical situation. These changes occur without alteration in the red cell magnesium or in the red cell chloride.

In the number of hospitals in which we have made rounds, it is common to find a patient with an i.v. going that actually has pitting edema. When you ask the question, "Why is this patient receiving intravenous fluids?" — the answer is that the patient is an alcoholic.

If you ask what clinical sign of dehydration was found upon examination, you never get past the dry mouth. Normally, a dry mouth, as we all know, is a valid sign of dehydration. And so patients continue to receive three, four, five six — in some deaths we have found that there have been as many as 15 liters of fluid given within 48 hours because the patient's an alcoholic. And when you drink, you urinate. What about the dry mouth? We have to get past the stage of the dry mouth. Alcohol is also lost via the lungs. And as a vapor it dries the mucous membrane of the mouth and in this instance has nothing whatsoever to do with the water content of the body. Alcohol also reduces salivary flow.

In the clinical study, another sign that physicians have used to indicate that patients are becoming dehydrated is the fact that once the alcohol ingestion has ceased and you follow the urinary output and fluid intake, as we did in the clinical study here, you will find that the urinary volume exceeds that of the fluid intake for two, or three, or four days, depending upon the degree of the over-hydration. Many times we have heard this and seen this in our own teaching hospital, that the patient is becoming more dehydrated, so push the fluids harder, because in looking at output and input data it appears the subject is in negative water balance. During the withdrawal phase the body actually compensates and removes the excess solute as well as solvent from the body. These patients come back to normal fluid and electrolyte balance within three to five days with skillful neglect as far as intravenous feedings go.

In summary, in the experimental and clinical situation in a patient population in which vomiting and/or diarrhea has not been superimposed, we have found in 94 percent of the cases over-hydration rather than dehydration. There is a marked retention of sodium, potassium and chloride, and a depletion of the total exchangeable amount of magnesium.

Myth: Alcohol is a Solubilizing Agent that Decreases Serum Lipids and May Prevent One's Developing Arteriosclerosis

In the latest medical pathology books one finds out that there is a very low incidence of arteriosclerosis in the skid-row, alcoholic-type population. This low incidence has been considered characteristic of all alcoholics.

If we go to the experimental lab once again we find the following results. Triglycerides were measured weekly in animals that received alcohol daily for three months. There is an immediate and sustained increase in the plasma concentrations of triglyceride throughout the period of alcohol ingestion. Remove the alcohol and the triglyceride concentration falls very rapidly back toward the control values. There is a similar response for the lipid phosphorous — increase during the alcohol period, return to normal once the alcohol has been taken away.

We find our greatest changes in cholesterol. It takes longer to produce. It also takes longer for it to return to normal once the intake has stopped. When we go to the alcoholic population we find a marked increase in the plasma concentration of cholesterol.

It has been thought that because alcohol is an excellent solvent for fats *in vitro*, the same thing existed *in vivo*. We now know that, contrary to popular belief, when ethyl alcohol is metabolized, it does not all go to CO_2, water, and glucose. If you use a C_{14} tagged alcohol and invest this radioactivity as ethyl alcohol, you will detect the C_{14} tage in fatty acids, triglycerides, phospholipids, and cholesterol — fats. Alcohol itself increases the sythesis of fats within the body.

When you place someone on a normal diet and he drinks, the amount of fat that you find in the blood is increased, not reduced, there's no doubt about it. It's increased because, first, there's an increased rate of synthesis by the liver. The metabolism of alcohol goes in partially to fat metabolism. The liver then increases the rate of production, but it has been recently shown that the liver hepatic cell can only handle so much of this fat. So what we see initally is an increased amount of fat in the blood with the gradual development of a fatty liver. Usually at any talk on alcoholism, when you mention the liver everyone thinks of cirrhosis, because cirrhosis and alcoholism go hand in hand. But here again the incidence of cirrhosis in alcoholics when properly diagnosed is less than 10 percent, even in the skid-row population.

What about all the earlier forms of liver damage? One of the first defects that occurs in the liver is the accumulation of fat because of the increased rate of synthesis. Alcohol is hepatotoxic; there's no doubt about it, regardless of how many vitamins or how many grams of protein you take in a day. The liver can become enlarged. If you biopsy the liver, what you usually find is fat. Take the alcohol away and the fat in the blood will come back to normal, the liver will recede, and the liver function will come back to normal.

Alcohol is also cardiotoxic. Instead of reducing the workload on the heart, it increases it. Normally, free fatty acids are the major substrate for the myocardium. Following the ingestion of nonintoxicating amounts of alcohol, free fatty acid uptake falls and triglyceride uptake increases. And the triglycerides are not used nearly as efficiently as are the free fatty acids. Consequently we start to get a build-up of fat within the heart. The increased workload may be brought about by the accumulation of fat, but it also may be brought about because, rather than a dilation of the coronary arteries, we find a constriction and a reduced coronary flow. Even in nonintoxicating amounts alcohol is toxic to heart cells. I say this because if you place a catheter in the coronary sinus and actually do an A-V difference across the heart, in the coronary sinus blood you will find increased concentrations of potassium, phosphate, dehydrogenases, transminases, over that of arterial blood. You will find reduced stroke volume and decreased contractility. After two weeks of daily alcohol ingestion there is a two-fold increase in the triglyceride content of the left ventricle.

This information may well help to explain the number of unexpected deaths from shock following surgery, especially among trauma patients. Alcohol reduces the contractility of the myocardium; when the heart is challenged while alcohol is in the blood, the heart is placed in a compromising situation because the mycordial reserve is reduced.

This is an area that I am sure we are going to hear considerably more about in the coming years, but again it is one to which we have given a considerable amount of denial. We can go to the early literature and find reports of the cardiotoxicity of ethyl alcohol.

Myth: Alcohol Builds Blood, i.e., Stimulates the Production of Blood Cells

Although alcoholism and anemia have been associated for many years, the anemia has usually been explained on the basis of deficiency of vitamin B_{12} or folic acid or both. Some current medical literature advocates the use of alcohol (primarily wine and beer) for the treatment of anemia. Only recently has it been recognized that alcohol can depress erythropoietic function.

In dogs receiving alcohol daily for three months, we have found a gradual and sustained decrease in the hematocrit, hemoglobin concentration and erythrocyte count. A marked normocytic, normochromic anemia was resultant. Since I have presented data indicating an increased plasma volume, one might conclude that these changes were the result of hemodilution alone. However, by determining the red cell mass (Cr51 tagged cells) we find a more gradual reduction throughout the period of alcohol administration. Certainly, then, hemodilution is not the answer. If we use the reticuloycte as an index of erythropoietic activity we find during the period of alcohol intake an absolute reticulocytopenia. Upon biopsy of the bone marrow during this period it was found to be hypocellular. It is important to note that this alcohol-induced anemia could not be prevented by giving massive intramuscular doses of vitamin B12 and folic acid daily. Following the cessation of alcohol ingestion all of these erythroid values returned to the normal range within a month. Indeed, reticulocytes increased daily during the first seven days of abstinence from alcohol at which time there was a significant reticulocytosis. Clinically, such a response has been taken to indicate that alcohol stimulates red-cell production. This reticulocytosis, however, represents the response following the withdrawal of alcohol. Often a normochromic, normocytic anemia results without any evidence of vitamin deficiency in the well-nourished alcoholic. Indeed, alcohol can produce toxic changes in the erythroid series of cells that are indistinguishable from those seen in chloraphenicol toxicity.

Myth: Alcohol Combats Infection

This myth is not held valid by most medical persons; however the lay public strongly believes that alcohol has bacteriostatic and possibly bacteriocidal properties, thus the prevalent use of the "hot toddy." Physicians, however, have long recognized an increased susceptibility to infection in the alcoholic population.

Experimentally, we have found various degrees of leukopenia, i.e., a dose dependent type relationship. This has been true for all of the other areas that I presented. The greater the dose, the greater the change. During the period of alcohol administration the hypocellularity of the bone marrow is not due to the erythroid series of cells alone, but also to the myeloid and lymphoid series of cells. Following cessation of alcohol ingeston, the leukocyte count returns to the normal range more rapidly than the red blood cell count.

Clinically, in the last two and one half years, the average white blood cell count upon admission to the alcoholic unit has been about 4,000 per mm3. Many times when these patients are stressed by bacterial infection it is not unusual to see a greater leukopenic response. It has been demonstrated that there is actually a decrease in the granulo-cytic reserve. This reduction in leukocytic reserve could in part contribute to the increased susceptibility to infection. In many patients with acute alcoholic hepatitis we find a marked decrease in the circulating amount of gamma globulins, which could also contribute to an infectious diathesis.

Concluding Remarks

What I have said is that one can *not* drink all he wants as long as he eats and feel secure that no harm will come to his physical well-being. Possibly I should end by saying if the only way you could buy ethyl alcohol today would be on a prescription basis, meaning that it would have to be approved by the Federal Food and Drug Administration, you could not buy it. It is hoped as new information appears in medical literature that this can be used to improve the medical management of the alcoholic patient. We find that physicians are accepting their responsibility much more readily by knowing something about the drug. Thus, understanding the effects of this drug on a scientific rather than an emotionally empiric basis is important to the proper medical management of a patient population which will get much larger before it is reduced.

REFERENCES

Bears, J. "Some effects of alcohol on the body." Paper presented at the three training classes for Memphis State University Alcohol Training Project, Memphis, Tennessee, March, July, September, 1976.

Blacker,E., Demone, H., and Howard E. Drinking behavior of delinquent boys. *Quarterly Journal of Studies on Alcohol,* 1965,*26*, 256.

Cahn, S. *The treatment of alcoholics: An Evaluative Study.* New York: Oxford University Press, 1970.

Davis, V. and Walsh, M. Alcohol, amines, and alkalids: a possible biochemical basis for alcohol addiction. *Science,* 1970 *167,* 1005.

Engleman, E. *Alcoholic beverages and government. Bulletin of Social Medicine,* 1961, *3,* 5.

Fox, R. *Antabuse as an adjunct to psychotherapy. New York Journal of Medicine,* 1958, 58, 1540.

Goldberg, L. Effects of ethanol in the central nervous system. In: Popham, R. ed. *Alcohol and Alcoholism.* University of Toronto Press, 1970.

Grossman, H. *Grossman's guides to wines, spirits and beers.* New York: Charles Scribner's Sons, 1964.

Leake, C. and Silverman, M. *Alcoholic beverages in clinical medicine.* Chicago: Year Book Medical Publishers, 1966.

Lieber, C. and Davidson, C. Some metabolic effects of ethyl alcohol. *American Journal of Medical Science,* 1962, *33,* 319.

Medical World News. Alcoholics: America's most destructive drug problem. *Medical World News,* 1971, *12,* 43.

Mendelson, J. and La Dou, J. Experimentally induced chronic intoxication and withdrawal in alcoholics. *Quarterly Journal of Studies on Alcohol,* 1964, *Suppl., 22,* 14.

Mendelson, J. and Stein, S. Serum cortisol levels in alcoholic and non-alcoholic subjects during experimentally induced ethanol intoxication. *Psychosomatic Medicine,* 1966, 28, 616.

National Institute on Alcohol Abuse and Alcoholism (booklet). *Alcohol and Alcoholism: Problems, programs, and progress.* Washington: U.S. Government Printing Press #1724-0240, 1972.

Chapter III

PSYCHOLOGICAL APPROACHES

The psychological theorists assume that alcohol abuse is a symptom of an underlying personality or emotional disorder. The majority of psychiatrists believe that one can completely "dry out" the alcoholic with medical treatment, but that there must be an investigation into the psyche before treatment and recovery can be completely successful.

This chapter is divided into the following sections: (1) psychological factors associated with the alcoholic personality; and (2) psychological treatment approaches, further subdivided into transactional analysis, behavior modification, psychodrama, gestalt, group therapy, and interpersonal communication skills.

Psychological Factors

Psychologists and psychiatrists have described alcoholic drinkers as neurotic, maladjusted, unable to relate effectively to others, sexually and emotionally immature, isolated, dependent, unable to withstand frustration or tension, poorly integrated, and marked by deep feelings of sinfulness and unworthiness. Some have suggested that alcoholism is a disastrous attempt at the self-cure of an unseen inner conflict, and might well be called "suicide by inches" or a self-destructive tendency (Menninger, 1938).

Freud emphasized the release from inhibition afforded by alcohol, allowing the expression of repressed urges, especially oral dependency and latent homosexuality (NIAAA, 1972). Others have attributed alcoholism to an unconscious need to dominate, or an attempt to escape from guilt feelings, or an inability to give or accept tenderness or love (Lolli, 1960). Many researchers have accumulated data to demonstrate that alcoholic individuals often come from broken or unhappy homes, and have undergone serious emotional deprivation during their childhood (Maddox, 1962). The Adlerian view is that alcoholism represents a striving for power, which compensates for a pervasive feeling of inferiority.

Contrary to popular belief, alcohol does not relieve anxiety and depression in chronic drinkers. Instead, it makes them more anxious and depressed. It also accentuates other psychological problems such as guilt feelings and lack of self-esteem. Thus while individuals may have begun drinking as an escape from unpleasant psychological realities, their continued drinking actually creates a vicious circle in which their problems are multiplied, not eased or released.

Treatment Strategies

(This section was adapted from a project entitled "Applied Training for Alcoholism Specialists Program," constructed and developed by Kenneth W. Wanberg and Gary Q. Jorgeson of the Fort Logan Mental Health Center and University of Utah.)

In the past few years, several different treatment strategies have been developed in the field of psychology and mental health. Some have a longer history than others. Although many are being used in alcoholism treatment centers throughout the country, few were developed specifically for the rehabilitation of the alcoholic. Some of these strategies will be briefly reviewed.

Strategy 1: Transactional Analysis

Transactional Analysis (TA) had its origin in the works of Berne (1961; 1964; 1966). Essentially, TA is a personality theory which has become a basis for therapeutic intervention. Its paradigm involves the concept that each person has three ego states: a parent, an adult, and a child. The model focuses primarily on transactions which occur among these three ego states within one person or between persons.

The exchanges or transactions between two people may involve various combinations of these ego states. For example, the parent in one person ("you should not have done that") may evoke a response from the child in another person ("I will if I want to"). The reinforcements for the transactions are called strokes, and these may be positive or negative. TA theorists suggest that negative strokes can be as powerful as reinforcers of transactions as positive strokes.

A critical concept in TA therapy is what the theorists call the life script of the person. Essentially this is the life plan which the child adopts, and which can be seen only by looking at how the child expresses himself. A general goal of TA therapy is to change the life script to one that is more healthy.

According to TA theorists, people get caught up in a game in which one of the ego states does not know what the other two are up to. The purpose of therapy in the TA framework is for the person to become aware of the way the adult, child and parent express themselves within and between persons. (See Harris [1969] for a more thorough description of the TA strategy.)

A current TA position involving problems related to the excessive use of alcohol is that alcoholism is a game in which the alcoholic engages in exchanges to gain interpersonal advantage (Steiner, 1969). There are several games that alcoholics play; however, three specific ones have been noted. They are: Aggressive — "Drunk and proud of it," Psychologically self-damaging — "Lush," and Tissue self-damaging — "Wino." Steiner (1969), who has claimed success in using the TA model for treating alcoholics, suggests that alcoholism can be "cured" or that once the alcoholic is aware of the "games" he plays, and desires to change his life script, he can drink socially. Certainly, Steiner's position has created considerable controversy with those who advocate the disease concept of alcoholism.

It seems, however, that one of the primary benefits of TA in treating persons with drinking problems is that it provides the patient (as well as the therapist) with a rather simple personality theory. Once the TA language has been adopted, labeling and defining of behavior, motivations, and goals is possible. Whether such labeling or even the overall TA model is successful in treating persons with problems related to excessive drinking is a question unanswered at this point. Research into the efficacy of this approach to treatment is needed.

Strategy II: Behavior Modification

Behavior modification therapy is based on a social learning model (Bandura, 1969). This model assumes that a maladaptive response or behavior is a manifestation of an attempt to cope with the external world and the individual's self-expectations. The behavior is reinforced if it facilitates coping and helps to reduce anxiety. The behavior therapist does not focus on the internal forces which hypothetically cause the deviant behavior. In fact, behavior modification assumes that preoccupation with internal determinants of behavior may result in failure to perceive the external variables that exercise control over behavior (Bandura, 1969). The behaviorist would, for example, reject the "disease concept" or the psychoanalytic theories of alcoholism as irrelevant to the immediate therapeutic aims of treatment.

The approach of the behavior therapist is to identify problem behaviors which may be maladaptive or deviant and develop reinforcement or punishment contingencies that will extinguish or modify the undesirable behavior. Thus, behavior therapy aims to control or modify behavior through the consequences or outcome of the behavior itself. Bandura (1969) suggests that there are two broad classes of consequences: positive reinforcements (rewards); and aversive consequences (punishments).

In addition to these two broad consequences of behavior which are basic to reinforcement schedules, there are three approaches to behavioral change coming out of laboratory studies. The first is the elimination of the maladaptive behavior through such learning principles as extinction or reinforcement of competitive responses with the undesired behavior. This is a direct attack on the behavior itself and is represented by the classical conditioning school (Hull, 1943; Pavolv, 1927). Aversive (Pavlovian) or positive (Wolpe, 1958) reinforcers are used in this approach. The second approach arose out of the operant conditioning paradigm (Skinner, 1938) in which the organism's behavior is shaped through reinforcement of positive behavior or punishment of undesired behavior. Whereas the first approach is represented by the stimulus-response model, the second is represented by the response-stimulus model. The third approach is represented by the social learning concepts of modifying behavior through modeling or vicarious processes (Bandura, 1965; Bandura and Waters, 1963; Bandura, 1969).

The use of aversive consequences in the classical conditioning paradigm to modify excessive drinking behavior is certainly not a new strategy. Kantorivich (1934) reported the first systematic application of aversive counterconditioning, and Lemere and Voegtlin (1950) reported findings of the most extensive study to date. In this strategy, the aversive stimulus is emetine-induced emesis and alcohol is the conditioned stimulus. Conditioning trials are continued until the ingestion of various liquors alone produces the conditioned response (emesis). For this paradigm, studies generally report about 50 percent abstinence after significant periods of time (Bruhn, 1963; Frank 1963; Blake, 1965, 1967; Lemere and Voegtlin, 1950). Other forms of aversive stimuli have been used in this approach including apnea, electric shock and covert sensitization where subjects are instructed in imagining adverse consequences of drinking such as vomiting (Catela, 1967).

Some criticisms have been leveled at the aversive conditioning approach, a major one being that a large proportion of alcoholics do not respond to the method. Another primary criticism is that the elimination of the drinking behavior is not in itself a solution to the personal life problems often existing with the alcoholic.

Another primary criticism is that the use of aversive stimulus merely represses the undesired behavior without replacing it with positive experiences. Thus, aversive conditioning seems to be more effective when coupled with other forms of therapy (Thimann, 1949; Voegtlin and Broz, 1949).

Wolpe (1958) has developed a method of desensitizing clients to specific fears and anxieties while under a state of deep muscle relaxation. This approach is based on the concept that anxiety is a major cause of inappropriate avoidance behavior (excessive drinking). Recently Cautela (1967) reported a study in which alcoholics were desensitized to stressful interpersonal experiences that normally would cause them to use alcohol to handle the stress.

The operant conditioning model allows an even greater possibility for utilizing positive reinforcers to shape behavior of a more desirable nature. Rather than focusing on the undesirable behavior, positive and desirable behaviors are rewarded. This approach is quite new in the field of alcoholism, and is being developed in several ways, such as the token system (Narrol, 1967). The development of reinforcement schedules (reward preferences) for individual patients would be an initial approach to this strategy (Keehn, Bloomfield and Hug, 1970).

Observational or vicarious learning of behavior of a more adaptive nature (Bandura, 1969) may become an effective means of replacing maladaptive behavior of persons considered alcoholic. Continuous and intensive exposure to models, whether they be trained therapists or lay persons, is certainly a phenomenon that, although not yet tested for its efficacy among persons considered alcoholic, probably is a primary force in producing change in the more traditional therapy setting. In a sense, this is close to therapy based on role-theory, the next strategy to consider.

Strategy III: Psychodrama — A Model for Role Change.

The above two therapy strategies have as their goal the change of behavior through (1) a change in the balance of ego status within the person or (2) a change in the external behavior of the person by either punishing undesirable behavior or reinforcing positive responses. The strategy of psychodrama also has the goal of changing behavior through focusing on specific social and personal roles that have become maladaptive.

Certainly, psychodrama is not a new strategy to be used with persons considered alcoholic. It was first reported being used with alcoholics as early as 1944 at the Moreno Psychodramatic Institute in New York, about eight years after Moreno founded the institute. Although since then, many reports have indicated its use in the treatment of alcoholism, only recently has the technique found wide usage in treatment programs. (See Weiner, 1964, for a historical perspective on the use of psychodrama with alcoholics.)

Psychodramatic therapy combines verbal expression and physical motion with quasi-life figures currently existing in the person's real world. Yet, it is structured in such a way that it is a drama — that is, some distinction is made between the drama and real life. The real situation is restricting in that the person invariably will slip into the old roles and behaviors that in fact are maladaptive, while the psychodrama allows him to try out various roles and to express feelings spontaneously.

The "classic" psychodrama will typically have three parts (Fairchild, 1970): the first stage is the "warm-up" process in which the leader (director) of the drama elicits verbal or physical expression from the participants. A natural warm-up occurs if the group spontaneously talks about their personal feelings or problems. If the group is restrictive, more structured exercises can be used in which the members of the group are asked to do or say something that is expressive of their current problems or feelings. The goal of the "warm-up" phase is to allow the group to cohere around one or several persons who become potential candidates as a protagonist. If the process narrows down to more than one person, then the director can select the one he is warmed up to or ask the group to do the selecting. The most successful dramas seem to occur when the group is warmed up to the problems and feelings of the selected protagonist.

The second stage in the psychodramatic process is the drama proper which is structured around the expressed personal feelings and problems of the protagonist. Effort is made to have the protagonist set up a specific situation or scene that demonstrates and evokes the personal problems or feelings with which the protagonist is struggling. The drama is facilitated through the use of a *double* to serve as self extensions of the protagonist and *auxiliary egos* to assume real life roles of significant others (e.g., wife). Action and invovlement are further catalyzed by several dramatic techniques: *role-reversal* in which the protagonist assumes the role of the auxiliaries; *mirroring* in which an auxiliary or another group member assumes the role of the protagonist to mirror back his actions and attitudes; projective *monologue* which allows the protagonist to verbally reflect on his current thoughts and feelings; and *behind-the-back* conservation in which the auxiliaries or other group members talk about the protagonist as if he were not present. The drama, then, begins with a specific situation and scene but will invariably shift to a here-and-now emphasis on the emotions and expressions, and on testing out of new roles, new words and new feelings. Often, before new rational roles and actions can be tested out, it is necessary to get a catharsis of the emotions and tensions going on within the person. This is accomplished through a dramatic climax in which the group members "become" the feelings the protagonist states are going on within him and the protagonist is positioned so that he must struggle with the feelings physically. The goal of this technique is to help the protagonist express the feelings not only verbally, but emotionally as well. This *emotional symbolization* may not be necessary if the protagonist is able to spontaneously express the feelings revolving around the drama. This affective peak is called the *climax* of the drama, and clears the way for insight into the personal feelings and problems which precipitated the drama. It allows the director to help the protagonist test out new roles in relating to the life situation. This may be the most creative portion of the drama itself.

The final stage is the closure or resolution and feed-back time. During this period it is important that all group members have a chance to talk about the feelings and problems that the drama stimulated within them. The focus, at least for awhile, is away from the protagonist and on the group members. Careful facilitation by the director is important in the closure of the drama so as to not allow the group to escape their feelings by talking about the protagonist. The closure is also a time when the "true" identities of the persons who played the auxiliary roles are established.

The psychodramatic process has many variations, such as the *socio-drama*, in which the problems common to the group are focused on, and the *projective chair*, which allows every person the opportunity to express or dramatize feelings to an empty chair by placing someone symbolically in the chair. Many values of the psychodramatic procedure seem apparent. A primary one is that it gives persons the freedom to express themselves in old roles and in a variety of new roles. Persons with problems related to excessive drinking are often very restricted in their interpersonal and social roles. Moreover, these roles are often maladaptive. The psychodrama, then, structures the kind of therapeutic experience in which the feelings and emotions revolving around roles and the anxieties and fears emerging out of the need to develop new and different roles can be explored and tested in a situation as close to real life as possible.

Strategy IV: Gestalt Therapy

A reaction to what some felt was a dehumanizing trend in traditional psychology was the development of the humanistic psychology movement (Maslow, 1968). Although preceding the development of this school, the Gestalt approach to therapy (Perls, 1951) in many ways became the practical application of the basic concepts of humanistic psychology (see Perls, 1969).

The primary principle in Gestalt therapy is focusing on "here and now" feelings with the purpose of bringing together intellectual (head) and affective (gut) experiences into a meaningful whole. Therapy helps the person to become more aware of his own experiences with the idea that a healthy person is in touch with himself. Nonverbal techniques — putting emotional feelings into physical action — are used to bring about this awareness of self. Stress is placed on helping the person recognize how he avoids awareness.

The use of Gestalt therapy principles in treating persons considered alcoholic would play down the focus on drinking behavior and past experiences. Talking about past drunks would be taboo unless these were integrally tied into current "here and now" feelings. The emphasis would be on helping the person be responsible for his own feelings and actions. The goal would be to help the alcoholic person depend on himself and not others, to move from environmental support to self-support (Perls, 1969). With alcoholics who are very dependent and caught up in a matrix of dependency relationships, this goal of gestalt therapy may be slow and tedious. The trap to avoid, according to the gestalt approach, would be allowing the alcoholic patient to transfer his dependency relationship from others onto the therapist. In this model, then, care is taken to avoid providing interpretations and supportive responses that defeat the purpose of helping the person to become self-supportive.

Strategy V: Treatment Through the Group

The treatment of persons with excessive drinking problems through group therapy is not a new strategy. In fact, it was probably the first technique to produce demonstrably successful results with alcoholics. This is not to say, however, that there is any one clear mode of group therapy that has been systematically used with alcoholics.

The purpose of ths brief discussion is to present a clear and distinct model for group therapy with persons considered alcoholic. The theoretical framework for the stratey comes primarily from the works of Bion (1961), Whitaker and Lieberman (1964), Glassman (1964), Kadis (1963), and Valom (1970). It is best described by Kadis' (1963) concept of group-centered therapy (versus therapist-centered) or Glassman's (1964) concept of therapy *of* the group.

Most often, group therapy is therapist-centered; that is, the therapist treats patients within the group. Most communication takes place between the therapist and the individual patient on whom he is focusing. Another common approach is to use the various interactions among group members to treat an individual member of the group.

This is what Glassman (1964) calls therapy with the group, yet, even though the interactions among group members are used, the final focus and concern of the therapist is still on one or several group members.

A third model, then, is therapy of the group. In this respect, the primary concern of the therapist is the group, which becomes his "client," on the assumption that the group, when treated, can evoke basic curative elements which will bring its members to better adjust (Yalom, 1970). The purpose is to develop a healthy group with the idea that a healthy group will produce healthy members (Bion, 1961).

The therapist in this model, then, uses everything at his disposal to facilitate group trust, cohesion and integration. He reinforces behavior on the part of the group that helps to establish these goals. If he focuses on any group member, it is not to treat or change that group member, rather to help the group move along towards integration and health. The facilitation of conflict-resolution, identifying and facilitating the struggles around group themes and issues, and helping the group to have a meaningful and satisfying experience are all primary goals of the therapist.

Many alcoholics seem to respond to positive group experiences. It is not an easy task to "treat the group," yet, the approach in this task is similar to that of treating the individual patient on a one-to-one level. The therapist never forgets he has an "individual" — the group — as his primary concern. The result, with concerted effort, is a healthy group, and a healthy group will help to produce a healthy person (Bion, 1961).

Strategy VI: Interpersonal Communication Skills

(The following is adapted from a paper presented by Sydney Wolf, Ph.D., on "Counseling: For Better or for Worse" to the twenty-third annual meeting, Alcohol & Drug Problems Association of North America, Atlanta, Georgia, 1972).

Studies have indicated that there are individuals who are effective in human interactions and are especially competent at helping other people in distress. There are those too who are ineffective in interpersonal relationships and are extremely destructive at efforts to help other human beings. Important research on this matter dates back to 1960 when the efficacy of psychotherapy and counseling was questioned because studies contrasting psychotherapy-treated groups with control groups revealed no significant mean difference (Bergen, 1966). It wasn't until it was discovered that the variance of the psychotherapy-treated groups increased that researchers began to examine the data more closely in an effort to discover why more "treated" individuals received extreme scores on criterion measures of improvement than did their control counterparts. The increased variability of the treated groups indicated that some people were getting better and some were getting worse. Further investigations indicated that therapists contributed significantly to this increased variability, that is, therapists were responsible for people getting or getting worse (Traux & Carkhuff, 1967).

Research designed to contrast effective versus ineffective "helpers" revealed a number of traits which, when present in counselors, resulted in patient improvement but when absent led to patient deterioration. These traits and characteristics makeup a core of qualities which are present in high functioning individuals regardless of the specific role, discipline or function they are performing (Carkhuff & Berenson, 1969). Furthermore, whether the counselor's theoretical orientation is Freudian, Rogerian, Existentialist, etc. if he has the characteristics of the effective individual, he will be helpful in his efforts; when he lacks these traits and characteristics, he will be harmful. These counselor traits are correlated with improvement in vastly different populations. Whether one is working with alcoholics, college counselees, schizophrenics, delinquents, or any other definable group, he will be effective if he is high on the therapist variables. These traits and characteristics have also been correlated with a wide variety of criteria of improvement, such as changes in psychological tests, time out of institutions, independent ratings, self ratings, therapist ratings, supervisor ratings, etc.

Morevoer, studies indicate that the therapist variables may be measured reliably and validly, usually on 5 point scales (Carkhuff, 1969). These scales are operationally defined and one may evaluate a helper's performance by reading the transcript of his interactions, listening to audio tapes of his performance, or actually viewing his interactions, through one-way mirrors or on video tape. Ratings made in this way by individuals who are discriminating and perceptive are highly correlated with outcome criteria (Cannon & Carkhuff, 1969). Using these scales, normative data on the population at large have been obtained. Some of the findings will be enumerated.

On these rating scales, level 3 is arbitrarily set as the point of minimal helpfulness; that is, an individual who scores at level 3 or above is helpful and should achieve statistical outcome ratings of improvement in his patients, far exceeding those of low-functioning individuals. Sadly, on the average, most people function at level 2 (Carkhuff & Berenson, 1967). Thus, it is rare to find anyone who can provide even minimally facilitative conditions and who is helpful. Furthermore, experienced counselors and psychotherapists function, on the average, at about level 2. That is, even when one is desperate enough to pay money to obtain help, one may obtain a low-functioning therapist who is destructive. Graduate clinical psychology students entering their programs, on the average, function at level 2.5, a quite satisfactory beginning level which suggests a potential for growth. However, later in their training these individuals drop to level 2 (Carkhuff & Berenson, 1967).

A Human Relations Developmental Model and a Human Relations Training Model, adapted for alcohol abuse training by Drs. Thomas Porter and Griff Long from models of Egan and Carkhuff, are included as Tables 3.1 and 3.2. Also, Gazda's Global Scale of Interpersonal Communications Skills developed by Dr. George Gazda, University of Georgia and modified from Carkhuff's Scales of Interpersonal Processes, is included as Table 3.3].

Thus, it seems that often we train out the best qualities and characteristics of out potentially most helpful trainees. In a study where people were asked to give a list of individuals to whom they would not turn in time of need and a list of people to whom they would not turn when in distress, independent measures of these individual's helping abilities revealed that people turn to those who have naturally therapeutic personalities and refrain from contacting those who are low functioning (Carkhuff and Berenson, 1967).

The variables which have been measured, defined and which separate high and low-functioning individuals are the following:

Table 3.1
Human Relations Developmental Model

Facilitative Skills [To make easy — not to take action]	**Action Skills** [Making decisions, doing something about problems]
Empathy — seeing the world through the other person's eyes as to his feelings and what he is thinking.	Confrontation — telling it like it is. Point out discrepancies, i.e., "you say one thing and do another."
Respect — prizing the person as a worthwhile human being who has potential.	Immediacy — knowing what is actually being said and felt in the helping relationship.
Warmth — caring for the person by showing attention and interest.	Problem-solving — suggestion as to alternatives to reach a goal. Once a decision is made, then develop steps and substeps to reach goal.

← Swinging Skills →

Concreteness — being specific with feelings, behaviors, and experiences.
Genuineness — being for real, honest, truthful, and not fake or phony.
Self-disclosure — being able to say, "I've been there too." Being open with our own feelings, behaviors, and experiences.

Developmental Phases: Exploration ⟶ Understanding ⟶ Action

Table 3.2

Human Relations Training Model

Facilitation Stage | **Action Stage**

Self-exploration [Think] → **Better Understanding [Judge]** → **Action [Act]**

Self-exploration [Think]	**Better Understanding [Judge]**	**Action [Act]**
1. Client explores his behavior 2. Client examines his problems (Where is he?)	1. Client seeks action oriented self-understanding 2. Client "owns" the consequences of self-exploration (Where does he need or want to be?)	1. The client acts upon his understandings (How is he to get there?)

Phases

Pre-Helping	**Responding**	**Personalizing**	**Initiating**
Attending physically Attending psychologically	1. Primary accurate empathy 2. Respect 3. Warmth	1. Advanced accurate empathy 2. Confrontation 3. Immediacy	1. Problem-solving techniques 2. Behavior strategies 3. Action Programs
1. Posturing 2. Observing 3. Listening			

Swing Dimensions

1. **Concreteness**
2. **Genuineness**
3. **Self-disclosure**

Skills Or Dimensions Related To Each Phase

Purpose: To train clients systematically and directly in the life skills presented above in order that they may live more effectively with themselves and help others.

General Description: The model is systematic and not school-oriented. It can be changed in order to meet the needs of the clients. The model is eclectic, borrowing systematically from all schools and systems with the major bases of skills training (human relations and problem-solving), and the principles and techniques of behavioral change.

Table 3.3

RATINGS	**1.0 [Not helpful, hurtful]**	**2.0 [Not helpful]**	**3.0 [Helpful]**	**4.0 [Helpful additive]**
HELPING SKILLS	Makes the other person sorry he even talked to you; punishing, damaging	Slows down the conversation; plays it safe, not complete, premature	Encourages the other person to say more. Reflective, facilitative, helpful	The other person learns more about himself and becomes more able to help himself in future
EMPATHY	A response in which the helping person: Attends to neither the experiences, feelings, nor behaviors of the other person, is hurtful or punishing	A response in which the helping person: only partially attends to the surface feelings or confuses what the other person is saying regarding his feelings and experiences; reflects total experiences; but ignores feelings	A response in which the helping person: Reflects accurately and completely the other persons's surface feelings — does not confuse the helpee. The helper both hears and understands what the helpee says	A response in which the helping person: Accurately perceives and responds to the helpee's underlying feelings goes beyond reflective level (3.0) and into deeper feelings
RESPECT	Makes fun of, scolds, and "shoots the other person down," tries to impose own beliefs or values onto helpee, focuses attention on self-dominated conversation	Withholds himself from involvement with the helpee by declining to help, and/or ignoring what the helpee is saying; responds in a casual or mechanical way; gives "cheap" advice or premature advice before understanding.	Communicates acceptance of the other as person of worth, capable of thinking and expressing himself and able to act constructively; suspends judgment of the helpee	Demonstrates his willingness to be a helper; will make sacrifices and take risks of being hurt in order to futher the helping relationship; helpee experiences himself as a valued individual
WARMTH	Shows a lack of caring for, or belief in the helpee; has a disapproving facial expression, turns away or does other tasks while the helpee is talking	Expressions and gestures are absent or neutral; responses sound mechanical or rehearsed; fails to communicate caring in a non-verbal manner	Shows attention and interest clearly; nonverbal behaviors vary appropriately as the helpee's emotions vary	Wholly and intensively attentive to the interaction or relationship resulting in the helpee feeling complete acceptance and significance; physically closer than at level (3.0)
CONCRETENESS	Deals with the helpee in general or vague terms, or responds in a very specific but premature and hurtful manner	Is general, does not focus on specific situations concerning the helpee, helper may ask the helpee to be specific without being specific himself	Is specific and concrete in communicating understanding but does not point out the directionality emerging for helpee action; helper models being specific	Models and actively seeks or asks for the helpee to be specific: this may take the form of clarification, assisting the helpee to be clear, accurately summarizing or outlining a problem
GENUINENESS	Tries to hide own feelings or uses them to punish the other person	Uses a preconceived role; helper's responses are the same as the role being played but not the same as true feelings	Shows no signs of being false or phony but controls his expression of feeling so as to facilitate the development of the relationship .	Helper's verbal or nonverbal messages, whether they be positive or negative, are the same or in line with how he feels; the feelings are communicated in such a way as to strengthen the relationship
SELF-DISCLOSURE	Reveals nothing about self or discloses self to meet own needs	Does not voluntarily reveal personal information, but may briefly answer questions regarding his own feelings, thought, or experiences relevant to the helpee's concerns	In a general manner reveals in a real or genuine fashion his own feelings, thoughts, or experiences relevant to the helpee's concerns	Freely volunteers specific feeling, thoughts or experiences relevant to the helpee's concerns — may involve risk-taking for helper, helper reveals his uniqueness as a person
CONFRONTATION	Ignores discrepancies in the helpee's behavior that are self-defeating; closes off fruitful ways to investigate	Does not accept discrepancies in the helpee's behavior but does not draw attention to them either; helper is not clearly aware of possibly useful areas of inquiry	Indicates discrepancies without pointing out specific directions in which these lead; helper is tentative in comparing diverging or contradictory communications expressed by helpee	Clearly points out discrepancies in the helpee's behavior and the specific directions in which these discrepancies lead
IMMEDIACY	Ignores all cues or signs from the helpee regarding the here-and-now or immediate relationship	Consciously gives token recognition about their interpersonal relationship but postpones discussing it or dismisses it.	Discusses the relationship with the helpee but in a general rather than a personal way	Clearly discuss the relationship with the helpee as it exists at that moment

Empathy. Empathy (Carkhuff, 1969) is the ability to accurately perceive what another person is experiencing and communicate that perception. At high levels of empathy, an individual adds noticeably or significantly to the communication, while at low levels, the individual detracts noticeably or signficantly from the communication.

Resepct. Respect implies that a helper appreciates the dignity and worth of another human being. It also implies that the helper accepts the fact that each individual has a right to choose, possesses free will, and may make his own decisions. Respect also indicates that each individual has the inherent strength and capacity for making it in life. At low levels, a person functioning without respect may over-protect, be condescending, or even hold another in low esteem or negative regard. He may make decisions, give advice, be falsely reassuring, or be hostile.

Genuineness. Genuineness (Carkhuff, 1969) is the ability of an individual to be freely and deeply himself. It is non-phoniness, non-role playing, non-defensiveness. A person who is genuine is congruent; there is no discrepancy between what he is saying and what he is experiencing. At low levels of genuineness a person may say one thing and communicate another non-verbally. He may be stiffly "professional" or be playing a role (rather than fulfilling a role). He may seem very different in the therapy room from what he is normally. People who function low in genuineness hide behind a facade.

Concreteness. Concreteness (Carkhuff, 1969) implies specificity of expression concerning the client's feelings and experiences. The concrete therapist keeps communications specific and gets to the what, why, when, where and how of something. Notions, thoughts, experiences are explored, in depth. The concrete therapist maintains relevancy in the communication and prevents the client from avoiding or escaping from theissues at hand. A low-functioning therapist who is not concrete is abstract or general. He is very permissive and allows the client to explore irrelevancies, to go off on tangents, and to maintain himself at an abstract level.

Confrontation. Confrontations (Berenson, Mitchell & Taney, 1969) occur when there is a discrepancy between what one is saying and what he is experiencing, or between what one is saying at one point and what he has said before, or between what one is saying and what his actions imply. This variable is totally under the control of the therapist and is initiated when the therapist feels it is appropriate. Confronting is risky and can precipitate a crisis, but it is often through such crises that the beginning of true growth occurs both in the therapeutic relationship and in the client's life. There are different kinds of confrontations possible in a counseling situation. For example, an experiential confrontation is a confrontation that occurs in the here and now, usually because what the client is saying and what he is experiencing are not congruent. There may be strength confrontations, when the therapist emphasizes a client's strength in the face of the client's communicated feelings of weakness. Weakness confrontations occur when the client is ostensibly presenting strength, but in fact, there are difficulties to be resolved and the client is avoiding them. There may be action, or didactic confrontations when the therapist transmits factual information.

Self-Disclosure. Self-Disclosure (Carkhuff, 1969) is the revealing of personal feelings, attitudes, opinions and experiences on the part of the therapist for the benefit of the client. The therapist, during self-disclosure, shares with the client some meaningful self-disclosing statements which may be pertinent to the issues. At low levels, the therapist never reveals himself, and maintains a screen of neutrality. Self-disclosure must be used with discretion and an accurate sense of timing and appropriateness. In all cases, self-disclosing statements should occur for the client's sake and not for the therapist's own catharsis.

Immediacy. Immediacy (Collingwood and Renx,

1969) is dealing with the feelings between the client and the counselor in the here and now. A high level of immediacy exists in the open discussion and analysis of the interpersonal relationship occurring between the client and the counselor, within the counseling situation. This is a very important variable because it provides the opportunity to work out problems and difficulties in an ongoing relationship so that the client profits from the experiences. The client can learn to restructure his interpersonal relationships by finding that it is possible to confront, to reveal oneself, and to express negative or positive emotions to another human being quite safely. Thus, the counselor who is immediate feels comfortable engaging in explorations of the present relationship between the client and himself.

Potency. Potency (Wolf, 1970) is charisma; it is the dynamic force and magnetic quality of the therapist. The potent therapist is one who has a force of presence. He is obviously in command of himself and communicates to others his sense of competence and security. The person who scores low in potency is milk-toastish, flat, a non-entity. He has little dynamism, little inner power. Such a person cannot evoke feelings of security; rather one feels uneasy in the presence of such an individual and would be reluctant to trust or burden him.

Self-Actualization. Studies have indicated that self-actualization is highly correlated with success in counseling (Foulds, 1969). That is, therapists who are themselves self-actualized serve as models of effective people who can live life fully and successfully. Self-actualization implies that one can live and meet life directly. Self-actualized people feel stress and tension but are not incapacitated by these negative forces. Self-acutalized individuals can live in the present and are primarily inner-directed. They are able to express themselves freely and openly. Their values are flexible, for these people are not judgmental or moralistic. Self-actualized people have the capacity for warm, intimate contact, and, in general, are extremely effective at living.

Strategy VII: Family Therapy

(This section was taken from Alcohol and Health, 1972, a special report presented by NIAAA on Alcohol and Health to the U.S. Congress from Secretary of HEW.)

Recently clinicians have reported successful use of family treatment methods, which is an advancement in the area of psychological approach (Essev, P. 1970, Meeks & Kelly, 1970). In this new approach to the study of alcoholic persons and their families Steinglass (1971) and his associates made observations in homes as well as in a treatment unit, with only spouses present or with children present as well. The researchers were impressed by the important part alcohol had sometimes played in the lives of all the family members.

In cases where alcohol served positively or adaptively in holding the family together, it became necessary to help that family develop alternatives once the drinking stopped. Alcoholic persons or their spouses often became more depressed for a time after drinking stopped.

Other problems did not go away immediately and some seemed to become worse. Also, very few of the couples reported having many close friends. However, while associating with other couples during the in-patient phase of the experimental treatment program, they seemed happier and there was a decided increase of interpersonal interaction. Although alcohol was freely available in this program, there was relatively little drinking after the first day or two. When the couples returned home, however, they almost always temporarily resumed drinking or became aware of missing alcohol greatly if they abstained.

More follow-up information about these couples needs to be obtained, and the number of couples treated is not large enough to justify definitive conclusions, but tentatively the researchers offer the following suggestions:

1. In treating alcoholism, attention should be given to family interactional factors in addition to individual problems.

2. Consideration should be given to the adaptive or positive functions that drinking served, so that the family may integrate these functions into their sober life through some other means, instead of having to give them up along with the alcohol. Failure to recognize this factor and deal with it by the development of viable alternatives to alcohol can have a de-stabilizing effect on the family.

3. Attention should be given to the family's extended social network. To this end multiple family groups as well as membership in A.A.and Al-Anon may be useful.

As a result of theoretical advances in family treatment, many alcoholism programs now routinely see the relatives of alcoholic patients. In some instances therapeutic efforts may be concentrated on a significant relative rather than on the problem drinker himself, often with ultimate benefit to the latter, since the beneficient changes in the family milieu may enable the problem drinker to recognize and accept his own need of help and arouse the desire to seek it.

Note: An effective treatment approach to working with family members is one developed by Vernon Johnson in his book, *I'll Quit Tomorrow*. Write: Johnson Institute, 7325 Wayzata Blvd., Minneapolis, Minnesota 55426 for further information.

THERAPEUTIC RELATIONSHIPS	*SOCIAL RELATIONSHIPS*
1. Always goal directed and purposeful.	— Usually no definite goals.
2. Set up to meet the needs of the patient.	— Set up for mutual needs satisfaction.
3. Helping person has a responsibility to evaluate his own behavior and to consciously use this behavior to help patient identify and meet his needs and modify his own behavior.	— No responsibility to evaluate behavior or attempt to help other person identify or modify his behavior.
4. Helping person has a responsibility to stay with the patient and work through problems that come up.	— No responsibility for staying with other person. Freedom to leave uncomfortable or problem situations.
5. Helping person expects to listen to and hear the patient's problems	— Expectation of mutual sharing of problems.
6. Helping person has specific skills to give to the patient and this difference is conscious and purposeful.	—Not necessarily any difference in skills and no obligation to use these skills.

Summary of Requirements, Interventions, and Relationships of Therapy

a therapy requires:
theoretical framework
general goals which are made
specific for the patient
specific techniques
contact between the
"helper" & the "helped"
implies changes in behavior
and/or personality
manifestations
empirical evaluation of its processes
implies Rx set of ethics
implies a role behavior for
therapist & client

THERAPEUTIC INTERVENTION

helps client extend his therapy goal & desired behavior into everyday living
is aware of relationship of client's behavior to his treatment goals
emerges out of the living situation
is examined to determine its congruence with requirements of patient therapy

Conclusions

The trainee at this point may be caught up in a web of confusion. What is the best approach to treating persons considered alcoholic? Certainly the above approaches differ in many ways. One approach focuses on the internal ego state of the individual whereas another is concerned only with the manifest behavior of the person. Aversive conditioning considers the drinking behavior as *the* problem and the Gestalt approach is concerned only with helping the person to find self-support by being aware of and accepting his own feelings and actions. One therapy encourages the patient to depend on external forces and systems (e.g., the group, family), whereas another strategy discourages this kind of support.

All strategies have the common goal of changing either internal ego states or external behaviors or roles to help the person better adjust to his world. Most strategies would recognize that the drinking behavior is a symptom of a breakdown in a healthy balance of the system or the ego states of the person.

The answer to which strategy is best may be provided in reference to the differential model for evaluation. Alcoholics from minority populations differ as to their manifest problems, their external social world, and their internal psychological state. The fact that *people* differ is the etiology for the development of different psycho-therapeutic strategies.

Thus, the basic principle of certain strategies may correlate with particular dynamics of certain kinds of alcoholics. A person who has little damage will need a therapy that focuses primarily on assisting him in abstaining from alcohol rather than focusing on reducing anxiety and tension.

Another person who has no social support system will probably not respond to a Gestalt approach until or unless he can be resocialized or finds some external support system. The latter may call for social role therapy such as psychodrama along with group therapy and a structured living setting.

What is not lacking in treating persons who are considered alcoholic is an abundance of treatment strategies. What is lacking is sophisticated research into what kind of strategies are best suited for what kind of patient. This kind of research does not happen overnight. Let us hope that the second 50 years of treating perosns with problems related to the excessive use of alcohol will lead us closer to that goal.

REFERENCES

Bandura, A. Vicarious processes: A case of no-trial learning. In L. Berkowitz (ed.), *Advances in experimental social psychology,* Vol. II, New York: Academic Press, 1965.

Bandura, A. *Principles of behavior modification,* New York: Rinehart and Winston, 1969.

Bandura, A. and Walters, R.H. *Social Learning and personality development.* New York, Holt, Rinehart and Winston, 1969.

Berenson, B.G., Mitchell, K.M., and Laney, R.C. Level of therapist functioning, types of confrontation and type of patient. *Journal of Clinical Psychology, 1969, 24,* 111-113.

Bergen, A.E. Some implications of psychotherapy research for therapeutic practice. *Journal of Abnormal Psychology,* 1966, 4, 235-242.

Berne, E. *Transactional analysis in psychotherapy.* New York: Grove Press, 1961.

Berne,E. *Games people play.* New York: Grove Press, 1964.

Berne, E. *Principles of group treatment.* New York: Oxford University Press, 1961.

Bion, W. *Experiences in groups, and other papers.* New York: Basic Books, 1961.

Blake, B.G. A follow-up of alcoholics treated by behavior therapy. *Behavior Research and Therapy,* 1967, 5, 89-94.

Bruun, K. Significance of role and norms in the small group for individual behavioral changes while drinking. *Quarterly Journal of Studies on Alcohol,* 1959, 20, 53-64.

Cannon, J.R. and Carkhuff, R.R. Effects of rater level of functioning and experience upon the discrimination of facilitative conditions. *Journal of Consulting Clincial Psychology,* 1963, 32, 189-194.

Carkhuff, R.R. *Helping and human relations: A primer for lay and professional helpers.* Vol. 1: *Selection and Training.* New York: Holt, Rinehart & Winston, Inc., 1969.

Carkhuff, R.R. and Berenson, B.G. *Beyond counseling and therapy*. New York: Holt, Rinehart & Winston, Inc., 1967.

Cautela, J. Covert sensitization. *Psychological Report*, 1967, 20, 459-468.

Chafetz, M. Practical and theoretical considerations in the psychotherapy of alcoholism. *Quarterly Journal on Alcohol, 20*, 281, 1956.

Clinebell, H. *Understanding and counseling the alcoholic*. New York: Abingdon Press, 1956.

Collingwood, T.R. and Renz, L. The effects of client confrontations upon levels of immediacy offered by high and low functioning counselors. *Journal of Clinical Psychology, 1969, 25*, 224-226.

Ellsworth, R., Foster, L., Childers, B., Arthur, G., and Krueker, D. Hospital and community adjustment as perceived by psychiatric patients, their families, and staff. *Journal of Consulting and Clinical Psychology*, Monograph Supplement, 1968, 32, 5, Part 2.

Fairchild, D. The use of psychodrama in treating the alcoholic patient. *Selected papers: Twenty-first annual meeting*, North American Association of Alcoholism Programs, 1969, 13-14.

Fairweather, G.W., Simon, R., Gebhard, M.E., Weingarten, E., Holland, J.L., Saunders, R., Stne, G. B. and Reahl, J.E. Relative effectiveness of psychoterapeutic program. A multi-criteria comparison of four programs for three different patient groups. *Psychological Monograph*, 1960, 74, No. 492.

Foster, F.M., Horn, J.L., and Wanberg, K.W. Dimensions of outcome following treatment of problems associated with the use of alcohol, submitted for publication, 1971.

Foulds, M.L. Self-actualization and the communication of facilitative conditions during counseling. *Journal of Counseling Psychology*, 1969, 16, 132-136.

Franks, C.M. Ease of conditioning and spontaneous recovery from experimental extinction. British Journal of Psychology, 1966, 1, 61-98.

Friedman, T.T. The psychiatric home treatment service: Preliminary report of five years of clinical experience. *The American Home Journal of Psychiatry*, No. 8, 1964.

Glassman, *S. What is group psychotherapy?* Denver: Fort Logan Mental Center, (mimeographed), 1964.

Harris, T. *I'm OK — You're OK: A practical guide to transactional analysis*. New York: Harper and Row, 1969.

Horn, J.L. and Wanberg, K.W. Dimensions of perception of background and current situation of alcoholic patients. *Quarterly Journal of Studies on Alcohol, 1970*, 31, 633-658.

Horn, J.L. and Wanberg, K.W. Symptom patterns related to excessive use of alcohol. *Quarterly Journal of Studies of Alcohol*, 1969, 30, 35-58.

Horn, J.L., Wanberg, K.W. and Appel, M. On the internal structure of the MMPI. *Multivariate Behavioral Research*, (in Press), 1971.

Hull, C.L. *Principles of Behavior*. New York: Appleton-Century-Crofts, 1943.

Jellinek, E.M. Phases of alcohol addiction. *Quarterly Journal of Studies on Alcohol*, 1952, 13, 673-678.

Johnson, V. *I'll quit tomorrow*. Minneapolis: Johnson Institute, 1974.

Kadis, A.L. *A Practicum of Group Psychotherapy*. New York: Harper and Row, 1963.

Kantrorovich, N.V. An attempt of curing alcoholism by associate reflexes. *Novoye Refleksologii Nervnoy I Foziologii Sistemy, 1928, 3, 436-445.*

Langsley, D. and Kaplan, D. *The treatment of families in crisis*. New York: Greene and Stratton, 1968.

Lemere, F. and Voegtlin, W.L. An evaluation of the aversion treament of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1950, 11, 199-204

Lolli, G. *Social drinking*. Cleveland: The World Publishing Company, 1960.

Ludwig, A.M. Studies in alcoholism and LSD (1): Influence of therapist attitudes on treatment outcome. *American Journal of Orthopsychiatry*, 1968, 38, 733-737.

Maddox, G.L. Teenage drinking in the United States. In: Pittman, D.J. and Snyder, C.L. eds. *Society, culture, and drinking patterns*. New York: Wiley and Sons, Inc., 1962.

Maslow, A.H. *Toward a psychology of being*. New York: Van Nostrand Reinhold Company, 1968.

Menniger, K.A. *Man against himself.* New York: Harcourt Brace, 1938.

McPortland, T.S. and Richard, R.H. Social and clinical outcome of psychiatric treatment. *Archives of General Psychiatry,* 1966, 14, 179-184.

Narrol, H.G. Experimental application of reinforcement principles to the analysis and treatment of hospitalized alcoholics. *Quarterly Journal of Studies on Alcohol,* 1967, 28, 105-115.

National Institute of Alcohol Abuse & Alcoholism. *Alcohol & alcoholism: Problems, programs, & progress.* Washington: U.S. Government Printing, 1972.

Partington, J.T. and Johnson, F.G. Personality types found among alcoholics. *Quarterly Journal of Studies on Alcohol.* 1969, 30, 21-34.

Pavlov, I.P. *Conditioned reflexes.* London: Oxford University Press, 1927.

Perls, F.S.*Gestalt therapy verbatim.* Lafayette, California: Real People Press, 1969.

Perls, F.S., Hefferline, R. and Goodman, P. *Gestalt therapy.* New York: Dell Publishing Co., 1951.

Polak, P. Patterns of discord, goals of patients, therapists and community members, crisis intervention service: Five Papers on Theory and Practice, Fort Logan Mental Health Center, Denver, 1970.

Skinner, B.F. *The behavior of organisms.* New York: Appleton-Century-Crofts, 1938.

Steiner, C.M. The alcoholic game. *Quarterly Journal of Studies on Alcohol,* 1969, 30, 920-938

Steinglass, P., and Associates. Interactional issues as determinants of alcoholism. *American Journal of Psychiatry,* 1971, 128, 275-280.

Voegtlin, W.L. and Broz, W.R. The conditioned reflex treatment of chronic alcoholism. An analysis of 3125 admissions over a period of ten and a half years. *Annals of internal Medicine,* 1949, 30, 580-597.

Wanberg, K.W. and Horn, J.L. Alcoholism symptom patterns of men and women: A comparative study. *Quarterly Journal of Studies on Alcohol,* 1970, 31, 40-61.

Wanberg, K.W. and Horn, J.L. Alcoholism syndromes relates to sociological classifications. *International Journal of the Addictions* (acepted for publication), 1971.

Weiner, H.B. Treating the alcoholic with psychodrama, *Group Psychotherapy,* 1965, 18, 27-29.

Whitaker, D.S. and Lieberman, M.A. *Psychotherapy through the group process.* New York: Atherton Press, 1964.

Wolf, S. An investigation of counselor type, client type, level of facilitative condition, and client outcome, unpublished doctoral dissertation, The Catholic Univ. of America. *Dissertation Abstracts International,* 1970, 31, Order No. 70-22, 093.

Wolpe, J. *Psychotherapy by reciprocal inhibition.* Stanford: Stanford University Press, 1958.

Chapter IV

SOCIOLOGICAL/ ANTHROPOLOGICAL APPROACH

One of the most promising avenues in the study of the causes of alcoholism has been the comparison of drinking practices and alcohol problems within and among various cultures and societies (especially minority populations). This approach, basically social and anthropological, but drawing upon physiology, psychology, nutrition, and epidemiology, is aimed at discovering why alcoholism is widespread in some national, religious, cultural and sub-cultural groups (minority populations) but rare in others.

In 1969 Cahalan, Cesin, and Crossley confirmed a suspected probability regarding drinking practices in America: "Whether a person drinks at all is primarily a sociological and anthropological variable rather than a psychological one." Thus, since that important study the sociological approach to alcoholism has secured a salient place in endeavors to explain alcoholism. In *The Etiology of Alcoholism* [*1972*] Roebuck and Kessler point to three developments which have yielded to the current preeminance of the sociological approach to alcoholism:

1) The failure to find a unique personality type or a unique psychiatric nosological group associated with alcoholism.

2) The importance of both sociological and social-psychological variables in alcoholism and problem drinking as reported (a) by a number of descriptive studies on drinking behavior and (b) by a number of studies of the association of sociocultural factors in alcoholism.

3) The development of operant conditioning theory, and its implications for the understanding of alcoholism and problem drinking.

Socioloical approaches to alcoholism are based on the assumption that there does exist a relationship between social structure and rates of alcoholism. Such social structure is generally treated at three levels: 1) the "supra-cultural orientation;" 2) the "sub-structural orientation;" and 3) the "specific-cultures orientation." As Roebuck and Kessler (1972) point out, these orientations or approaches do not seek to explain why an individual becomes an alcoholic, as do the constitutional and psychological approaches.

Supra-cultural

There presently exist several theories applicable to the supra-cultural orientations. However, Robert F. Bales' theory, a cultural transmission theory, is the most frequently mentioned. Bales in his "Cultural differences in rates of alcoholism" (1964) cites three ways in which culture and social organization can influence alcoholism rates:

1) The degree to which the culture operates to bring about acute needs for adjustment of inner tensions in its members.

2) The sort of attitudes toward drinking which the culture produces in its members. The crucial factor seems to be whether given attitudes suggest drinking to the individual as a means of reducing his inner tensions, or whether such a thought arouses a strong counter-anxiety.

3) The degree to which the culture provides substitute means of satisfactions.

A variation of this cultural transmission theory is that of differential association, which is based on three premises: 1) All behavior is learned; 2) Learning evolves out of a cultural context; and 3) Individuals are products of social collectivity.

Sub-Structural

The sub-structural orientation is applicable to those institutions and sociological variables which are considered salient factors in the cause of alcoholism. Roebuck and Kessler (1972) point out that the two social institutions most frequently discussed in relation to alcoholism are religion and the family; other variables considered are social class, sex, ethnicity, age, and urbanization.

There is currently a dearth of viable data on alcoholism rates for different religious groups. There are, however, logical trends observed. Perhaps the one and only case where high rates of drinking do not seem to be directly correlated with high rates of heavy drinking and alcoholism is with the Jewish population. Cahalan (1969) found that in environment support for heavy drinking Catholics were rated as above average and conservative protestants, below average.

Family studies have not reported consistent findings regarding the correlation between the family and alcoholism. However, Roebuck and Kessler (1972) conjecture that the parental role in the development of alcoholism is twofold; parents help create in the child psychic or adjustment problems, and they directly or indirectly encourage the use of alcohol to deal with these problems.

Age, sex, and ubanization also contribute to the substructural orientation. Cahalan (1969) has found that:

1) Men have a higher frequency of drinking problems than do women.

2) Men in their twenties are among the highest in terms of alcoholism frequency.

3) Men over 50 have a higher rate of symptomatic drinking than men in their forties.

4) Very few men over 70 have drinking problems.

5) Women who incur drinking problems incur them most frequently in their thirties and forties.

6) Women in their forties have a higher frequency of drinking because of psychological dependence than do younger or older women.

7) The size of a city is important in the prevalence of problem drinking, especially among men between 40 and 49 years of age.

8) The incidence of drinking-related problems involving psychological dependence is higher in larger cities than in smaller cities or rural areas.

9) The highest proportion of abstainers and infrequent drinkers is found in the 45-and-over lower status/lower urbanization group.

Specific Cultures

The specific cultures orientation deals with alcoholism in particular countries and cultures. Contributing factors to alcoholism, according to this orientation, would include societal ambivalence, negative sociocultural conditions, religious needs, existential anxiety, dependence needs, culturally prescribed aspirations, and modes of deviant behavior.

Anthropological Approach

(The following section is adapted from a paper by Dr. Billye Fogelman, Assistant Professor in the Department of Anthropology at Memphis State University. Dr. Fogelman has had many years of experience in working on research projects directly related to alcoholism and also as a trainer in various alcohol abuse projects in the United States).

When a phenomenon such as alcoholism is considered, it is clear that it cannot be adequately explained, prevented or controlled by purely medical approaches. The problem involves not only physiological and chemical factors, but also the cultural background of the individual, his emotional makeup, and the extent to which the susceptibility to alcoholism is inherited.

Most workers in the field agree that the majority of successes in the treatment of alcoholic patients have come about through supportive therapy combined with consideration of some of the underlying conflicts and anxieties of the patient. Thus, it is argued, the patient is aided back to a more helpful and hopeful outlook and toward a more satisfying pattern of living. The patient is helped to analyze social activities, family relationships, and occupational, marital, and sexual adjustments. Furthermore, he is helped to find his own ideology and to develop more beneficial avocational as well as vocational interests. Through therapy the alcoholic is led to find that life is more satisfying without alcohol than it is with alcohol.

How is such meaningful therapy accomplished? How do we come to understand a particular person's conflicts and anxieties, social activities, ideology, occupational adjustments, and marital and sexual relationships, and equally important, how do we aid the client to understand himself?

The thesis taken is that one very beneficial way is through the use of anthropology. Anthropology has relevance for counseling because of three important anthropological foundations: it is holistic, it employs the culture concept, and it uses the notion of cultural relativism. First of all, it is important to define and discuss the field of anthropology.

Definition of Anthropology

The word *anthropology* is derived from the Greek. *Anthropos* in Greek means man and *logia* means study. Anthropology then is the study of man. Many anthropology textbooks begin with one or more of the following quotations:

> "Trees and fields tell me nothing; men are my teachers" — Plato.
>
> "The true science and the true study of man is man" — Charron.
>
> "Know then thyself, presume not God to scan; the proper study of mankind is man" — Pope.

Holism

But other disciplines are concerned with man. Why then is anthropology called "the science of man?" The principal reason it can claim this distinction is that it sets as its goal the study of mankind *as a whole*. Many disciplines research an aspect of man and his actions, but no other professes to research all the manifestations of the human being and human activity in a unified way in all times and in all places. Anthropology is the study of the whole or total man. A fundamental principle in anthropology is that no part can be accurately understood apart from the whole or totality of man. Anthropology then is holistic. All facets of man may be related. It is the job of the anthropologist to show in what ways this is so. One examines all behaviors to determine relationships among persons, groups, and individuals, and never loses sight of the fact that all aspects of culture are inter-related.

Definition of Culture

It has been said that anthropology has relevance for counseling because of three anthropological foundations. The notion of holism has been previously discussed. The second foundation is the culture concept. Culture is the patterned ideas and beliefs any group shares and the artifacts of those ideas and beliefs. The classic definition is that of the English Anthropologist, E.B. Taylor, who in 1871 wrote: "Culture . . . is that complex whole which includes knowledge and habits acquired by man as a member of society."

Culture has been a long time being defined. Social scientists themselves have over 160 different definitions. But culture, even for nineteenth-century anthropologists, meant all human customs. Some confusion has arisen when it is used to refer to someone who is accomplished in the arts or social graces. "She has culture" of "He is a cultured person." The scientific term approaches more fully the original meaning of the word which is derived from the Latin verb colere (to cultivate or instruct) and the noun cultus (cultivation or training). Culture, in its broadest sense, is cultivated behavior; that is, the totality of man's learned, accumulated experience which is socially transmitted. This seems simple enough, but there are problems attached to the operation of this term, culture. A difficulty in the study of culture is that we are not in the habit of analyzing the customs which shape our behavior. Culture tends to be unconscious. But it is possible to develop techniques for studying culture. First, we describe an object or event. Then we learn that it is part of a pattern when it recurs. Next we ask, "What does it do?" and finally we ask, "What is its relation to the dominant values of the culture?"

Culture Relativism

A third foundation in anthropology is cultural relativism. A culture is created to suit the needs of the group using it. The culture works for the group of people using it. If it does not work, it changes and if the change is maladaptive, the culture will die out. Implicit in this notion of cultural relativism is that no one culture is better or worse than any other. It is only different.

How does one use anthropology to study an individual or a group of people? The crucial basis of the anthropological method is resident observation or participant observation in the group under study, whether it is a small island society in the Pacific, a neighborhood in some western city, or a group of persons who identify themselves as alcoholics. The anthropologist considers that the cultural system he examines receives its integration from the functional interdependence of each part of the culture. He looks at the group under consideration in this way and studies not only the specific culture, but also the influences of the larger society on the specific culture.

The Emic Approach

Participant observation means getting another culture into one's mind and muscles, learning to speak its language as well as one can, and participating in the life of the community to whatever extent the people and one's own personality will allow. This methodology is known as the emic approach to cultural analysis.

How is this done?

First of all, language must be learned, and most importantly the anthropologist must learn to understand in *their* terms what his subjects are trying to tell him. It is important not only to learn the spoken language of your subjects, but also to look at paralanguage (the pauses, stutters, pitch, and tone of the language,) kinesics (body language and space), and metalinguistics (the totality of speech patterning in a community in social context). For example, Black women now deplore being addressed as "girl," although some men think they are paying an adult woman a compliment to call her something alluding to her youthful appearance.

Another facet of culture that must be studied is technology; that is, the housing, clothing, transportation, food, and manufacturing.

A third facet is economic organization which refes to the techniques utilized in organizing the production, distribution, and consumption of goods and services.

Components of Anthropological Investigations

Social Organization refers to the means of cooperation and conflict between the various members of a given group. These groups may be the family, the extended family, clubs, organizations, and associations.

Ideology refers to the set of beliefs explaining the nature of the world and of man's relation to it. Values are a set of beliefs and actions held to be ideal or good.

Art refers to the exaltation of human experience through manipulation of the senses.

Political Organization refers to the formal and informal means men have of regulating relations within their own group and between groups. *Law*, in anthropology, is defined as a social norm, the deviation from which is sanctioned in threat or in fact by the application of physical force from a party possessing the socially recognized privilege of so acting. *Norms* are the accepted modes of behavior or beliefs of a given society. *Deviation* is breaking of norms. In order for an anthropologist to arrive at the social control mechanisms or to understand them he must know what the norms of the culture are. Each society selects from many alternatives in the formation of its cultural behavior. Human behavior must be narrowed down from its full range of potential variety to a moderately limited patterned body of norms. The culture of any society sets such patterns.

References

Bales, Robert F. "Cultural differences in rates of alcoholism." *Quarterly Journal of Studies on Alcohol*, 6:480-499, March 1946.

Cahalan, D., Cisin, S.H., and Crossley, H.M. *American drinking practices*. New Brunswick, N.J., Rutgers Center of Alcohol Studies, 1969, pp. 200-201.

Fogelman, B. *Anthropological approach*. Paper presented at five-day workshop on Memphis State University campus, 1976.

Roebuck, J.B. and Kessler, R.G. *The etiology of alcoholism*, Charles C. Thomas Publishers, Springfield, Illinois: 1972, pp. 139-222.

Chapter V

ALCOHOL ABUSE CONCERNS AND NEEDS OF MINORITY POPULATIONS

The following chapter deals with the social correlates of alcohol abuse in relation to minority populations. The minority populations considered are by: race (Blacks); sex (females); age (teenagers and geriatrics); region and residence (rural); and other (Spanish-speaking and the native American Indian). The chapter is divided into the following sections: the minority populations, demographic characteristics, incidents and outcomes, unique needs and concerns, treatment modalities, preventive measures, and research findings.

Minority Populations

There is an almost appalling scarcity of research on alcoholism in reference to minority populations and an even greater scarcity of services oriented toward any segment of the population that does not fall into the white middle-class category. Those few attempts which have been made to deal with this void have been traditional explanations, often based on ethnocentrism and cultural stereotyping.

Often it has been suggested that alcohol for minorities was the simple response to the effects of poverty, oppression, discrimination, and societal ignorance. While these aspects are perhaps necessary in understanding alcoholism and minorities, they do not imply an inevitable correlation.

Dr. Peter Bourne, past Director of the Office of Drug Abuse in Atlanta, Georgia, points out that there is not a consistent correlation cross-culturally between these states of deprivation and alcoholism and that a more valid explanation might be that "alcohol offers an accessible and immediate pleasure which there is almost no valid reason to defer" (Bourne and Fox, 1973).

Societal moralistic attitudes have also significantly contributed to the avoidance of dealing with minorities and alcoholism. For example, female alcoholism is seen by many Americans as the breaking of strong cultural taboos and "unladylike." Thus, there has been a reluctance to see female alcoholism as a grave problem. These moralistic attitudes are often observed in the Black community where the black minorities tend to see the alcoholic as a condemned sinner and not one who might profit from rehabilitative efforts. Too, as Bourne and Fox suggest, many Black ministers fear that a community treatment program might infringe in an area where they previously had exclusive prerogative.

In an atmosphere of widespread attention to the use of illicit psychoactive drugs by teenagers, relatively little attention has been given to the interrelation between teenage drug abuse and alcohol. Some current research indicates that the teenage alcoholic appears to be a threat to the parent who is an alcohol consumer in terms of his peer group's conception of the "good parents." Thus, often the parent, while aware of his child's alcohol abuse, will be slow to ask for help from an outside agency, and the problem is disguised or ignored.

Schmidt, Smart, and Moss in *Social Class and the Treatment of Alcoholism* (1967) suggest that minority populations who finally do receive treatment are likely to be diagnosed as a psychotic or suffering from chronic brain syndrome. They also point out that alcoholic minorities in general have a poorer prognosis than do alcoholics of a higher social class and are often given less intensive treatment. Thus, it becomes quickly apparent in researching rehabilitative and treatment trends that there has been very little effort in working with the alcoholic as an individual with individual needs. The Office of Economic Opportunity specifically concentrated its efforts in the past several years on the problem of alcoholism among minorities; this represents the first concentrated effort in the development of treatment and rehabilitation programs for minority populations.

Demographic Characteristics

A recent U.S. census has yielded a total population of 220,000,000 Americans. In the ensuing discussion regarding alcoholism and minorities it might be well to note the following percentages as approximate representations of each major minority population in the U.S.:

Females	51%
Youth (13-19)	24%
Non Whites	15%
Aged (ages 60 & over)	15%

Obviously, these minority groups as a single unit make up a large portion of the entire population. Yet, in terms of evaluative research in the areas of alcohol consumption, abuse, and treatment this significant group has been avoided with emphasis placed solely on the white male. Of further significance is the fact that within the non-white population the incidence of alcohol abuse is eight times higher than in the white male population.

Incidents and Outcomes

Citing statistical incidents accurately representative of minority populations in reference to alcohol is especially difficult for two major reasons. First, the definition of alcoholism varies with a particular setting. That is, when is a given way of behavior considered a problem behavior for a designated culture?. Secondly, there is an almost total absence of research oriented toward assessing the incidence of alcoholism in minority populations by any adequate criteria. Existing research fndings, however, do indicate several salient aspects of acloholism in the minority populations.

Blacks

In urban Black communities alcoholism ranks first as the major mental health problem, and there are those researchers who cite alcoholism as the most significant of all Black health problems. Also, data indicate that the rate of habitual drinking by urban Negroes is several times higher than that of the average urban society. Zax, Gardner, and Hart in an article on intoxication in Rochester reported that eighty percent of all Black men questioned had been arrested for public intoxication during 1961 alone, a rate which is twleve times that for white males. Yet, ironically, a recent study completed by Harper & Dawkins (1976) points out that literature dealing with Black alcoholism is scarce. In fact, in a review of Rutgers' *Classified Abstract Archive of Alcohol Literature*, only 77 articles out of 16,000 mentioned Backs and alcohol and only 11 of these articles dealt solely with Blacks.

Bourne and Fox (1973) suggest that while care must be taken to avoid excessive concentration on the relationship between historical and contemporary drinking patterns of the black population, it should be noted, however, that intoxication on the weekend for the Black urban poor is not considered expecially problematic nor deviant behavior. In ghetto communities liquor is often used to relieve the pressures of the preceeding week. Also, paychecks are often received on Friday afternoons, thus supplying the means for the purchase of the liquor. In such communities, many liquor stores report that they do not even open until Friday — closing again on Monday. In many Black communities, "sipping," the small, but consistent, consumption of alcohol throughout the day, is not seen as a deviation from the norm. However, in the white middle-class community such "sipping" could constitute alcoholism.

In Vitol's *Culture patterns of drinking in Negro and white alcoholics* (1968), data indicated that Negro adolescents tend to begin drinking alcohol at earlier ages than white youths. One third of the black youths between the ages of 12 and 14 interviewed were borderline alcoholics, as compared to less than 0.5% among the same age group in white youths.

Harper (1976) suggests that from information gathered it appears that Black Americans tend either to drink heavily or not drink at all. That is, moderate drinking among blacks is seldom observed. Harper cites further facts based on available information:

1. Blacks tend to be group drinkers, drinking with friends and relatives as opposed to drinking alone.
2. Blacks tend to drink more frequently and heavily during the weekends, probably due to tradition, Friday paydays, and free time off from work.

3. Blacks often use alcohol to facilitate conversation, fun, and sexual activity.

4. Many Blacks often drink in public on street corners, outside liquor stores, in automobiles; in front of homes and store-front businesses; and in public taverns and "joints."

5. Black men on Black college campuses often drink heavily in the party and group setting, especially on the weekends. (There seems to be no available published research comparing Black college student drinking practices with those of white college students.)

6. The young Black urban male in his 20's and early 30's is prone to heavy drinking and problem drinking that often lead to illness and/or police records.

7. Urban Blacks drink more than rural Blacks, and Black men drink much more than Black women.

8. Heavy drinking in given Black communities appears to be associated with health problems, social problems, and a high incidence of unemployment and unstable employment.

9. Blacks are status-conscious drinkers, often giving attention to the brand of liquor and the price. A larger proportion of Blacks than whites prefer Scotch, because of its status (Bourne, 1973).

Finally, Harper concludes that Black Americans differ significantly from the white population in their drinking patterns and points out the following:

1. Black alcoholics are often younger than white alcoholics and they often experience alcohol-related illnesses at a younger age.

2. A majority of Black women are nondrinkers (51 percent) as opposed to white women (39 percent); however, a larger proportion of Black women are heavy drinkers when compared to white women. (It seems that Black women tend to either drink heavily or not at all.)

3. The life style of Black skid row alcoholics is different from that of white skid row alcoholics (Blumberg, et. al., 1973) Black skid row alcoholics, as compared to their white counterparts, are less likely to get jobs, less likely to become homeless, are younger, drink much more on weekends, are less likely to be diagnosed as true alcoholics (as opposed to problem drinkers), and are less sophisticated in exploiting welfare resources and services. Furthermore, Black skid row individuals identify more with the nearby Black community than with the skid row community.

4. Alcoholics Anonymous (AA) has not had the same success with Black alcoholics as it had with white alcoholics. The successful AA groups involving Blacks tend to be those run in Black communities (Bourne, 1973; Davis, 1974).

5. The violent consequences of alcohol have been much more serious for Blacks (especially Black men) in terms of homicides, accident,s criminal assaults, and conflict with the law.

6. Black alcoholics admitted to hospitals and clinics show stronger motivation for treatment, fewer complaints, and greater cooperation during the treatment process than do white alcoholics.

7. Black alcohol-related language differs from the language used by whites.

8. Black alcoholics and problem drinkers are less likely than whites to seek out traditional treatment programs unless there is a crisis or mandatory need. The reasons for this behavior are that Blacks have not trusted the traditional white service system and Blacks have not been brought up to seek out helping professionals and helping institutions (Beverly, 1975).

9. A large proportion of Blacks who end up in treatment are referred to treatment or required to undergo treatment by the court or by various social agencies. In general Blacks tend to use fewer services than whites.

Frederick Harper in *Alcohol and Blacks: An Overview* (1976) discusses the following components as necessary in a treatment program with a significant number of blacks:

1. A plan of outreach in getting to know Blacks in the local community, in gaining their trust, and in getting Black alcoholics and their loved ones involved in *successful* treatment efforts.
2. A staff that consists of a significant number of persons who know the local Black community, who live in the community, who know the history of that community, and who know the problems of people who live in that community.
3. Health services through the cooperation of hospitals, clinics, and other health resources and programs.
4. Educational, leadership, service, and recreational activities as alternatives to constant heavy drinking. The Black alcoholic must be given *responsibility* for his behavior as well as the behavior of others.
5. Upgraded training for staff.
6. Effective evaluation and reporting on treatment outcomes and the overall success of the treatment program in achieving its goals.
7. Strong follow-up and support activity for alcoholics who have departed treatment; also means of preventing unnecessary revolving-door effects.
8. A culture-specific treatment orientation which would speak to the cultural style and needs of Blacks as well as to the general needs that are common to all alcoholics.
9. Close working relationships with courts, police force, and other legal systems that come into contact with the Black problem drinker who is likely to commit alcohol-related offenses.

Native Americans

Alcoholism is the number one major health problem for the American Indian. The secretary of HEW in his report to Congress on Alcohol and Health in 1971 stated that incidence of alcoholism among the American Indian was at an "epidemic level." The report further states that problem drinking among this population is twice the national average. Gary Forrest, clinical Supervisor of alcohol rehabilitation for the Department of the Army (1975), states that on certain Indian reservations the number of alcoholics includes from 25 to 50 percent of the total population and that three-fourths of all fines, arrests, and other legal involvements incurred by American Indians result from the abuse of alcohol. Other data indicate that Indian death rates from cirrhosis of the liver are three times the national average and that high rates of suicide among American Indians appear to be directly related to high levels of alcohol consumption.

Rehabilitation with Native Americans has been extremely difficult. However, a current rehabilitation program located in the Pacific Northwest and coordinated by the Mental Health Program of the Indian Health Services is reporting success in the treatment of Native American alcoholics. Such success is attributed mainly to the fact that the program is based on the reservation where the Native American's identity is maintained. Further support of this concept is evidenced in a residential treatment program for Native American alcoholics at the Mendocino State Hospital where a program was developed for this population which was physically segregated from the rest of the hospital's alcohol programs. The Native Americans were free not to choose this segregated program, but all did. Prior to the establishment of this segregatged unit at the hosptial, treatment of this same population was cited as unsuccessful.

Females

In a 1973 report in the *Quarterly Journal of Studies on Alcohol*, it was suggested that female alcoholics may well be the most "isolated" and "disaffiliated" group in the alcoholic population. There have been occasional studies of alcoholic women in prison, but it is doubtful that any findings from these studies can be generalized to the larger population of female alcoholics, especially homeless females on skid row.

Statistical evidence now shows an excess of 1½ million females considered alcoholic, but there exists very little statistical data reegarding incidence and outcomes. The World Health Committee on Mental Health as early as 1952 reported that female alcoholics begin to drink at a later age than do males but that the transition from controlled to uncontrolled drinking is more rapid for female alcoholics. Contemporary reports on female alcoholism point out that alcoholism among women is rapidly increasing.

As Kinsey suggested in *The Female Alcoholic* (1967), however, higher female alcoholism rates may be actually due to increased visibility of female alcoholism. Public attitudes are changing slowly, with diagnosis and treatment for the female alcoholic more open as compared to the traditional reluctance to acknowledge the problem. Also, more alcoholic women are emerging, who were once hidden, as acceptance and treatment become more apparent. Finally, the alcoholic female who manifests herself drunk in public places has become more common in the past two decades. Therefore, while there are those who project that female alcoholism has risen significantly, recent statistical data support the theory that in the past two decades female alcoholism has not shown a sudden, dramatic rise but has only become more visible.

Explanations of female alcoholism are numerous and diverse. Some suggest that female alcoholics indicate greater pathology than to other segments of the alcoholic population due to what Karpman (1956) sees as the female's subjection to repression. Greater variability in personality as compared to males, specific feminine physiological functions, sexual promiscuity, and dependency conflict and need for social aproval are all explanations given for female alcoholism. Joan Curlee in a paper commissioned by the National Center for Alcohol Education (1974) stated:

> Numerous authorities have pointed out that drinking problems are most likely to occur among persons who receive mixed signals from society about the acceptability of drunken behavior. Perhaps there is no group for whom the social signals regarding drinking behavior have been so mixed as for women.

Mary Gospodarek has presented three curricula for treatment of the female alcoholic:

1. *Reflections in a Glass* — or a "folks-teaching-folks" course for use by facilitators and trainers working with groups of women. NIAA is arranging for the design, production, and distribution of the course.
2. *An Ounce of Prevention* — deals with the drinking decisions of black Americans.
3. *The Power of Positive Parenting* — designed for use in helping parents understand how they can help their children develop realistic attitudes toward drinking.

Each of these courses is integrated by a facilitator who, with a handbook, leads groups in training activities.

Adolescents

Current data strongly support the contention that teenage alcohol addiction has become a serious problem today in the United States. Statistical evidence cites that approximately 1.3 million teenagers (ages 12-17) have serious drinking problems. The National Institute on Alcohol Abuse and Alcoholism report that 60 percent of those killed in drunken-driving accidents are teenagers and that the number of teenagers arrested for drunken driving has tripled since 1960.

Dr. Morris E. Chafetz, past director of NIAAA, reports that 14 percent of all high school seniors are intoxicated at least once a week, every week, and that by the age of 16, half of the teenage youth in high school are drinking in cars at night. Even among the ages 9-12, alcoholism is becoming serious. Dr. Chaftez states that alcoholic groups for teenagers are rapidly evolving throughout the country. Prior to 1970 none were noted.

In results from a study in the Second Special Report on Alcohol and Health, the largest study ever completed on teenage use of alcohol, it was cited that use of alcohol by youth in grades 7-12 was more extensive than ever before. It was reported that 63 percent of boys and 54 percent of girls in these grades have tried alcoholic beverages.

The past two decades have been periods of heavy marijuana use by youth. Teenage alcoholism and drug use were previously viewed as unrelated. However, according to the Commission on Marijuana, an association between alcohol and drug use does indeed exist. The commission states that "the overwhelming majority of marijuana users do not progress to other drugs; they either remain with marijuana or forsake its use for alcohol." Some teenage alcohol abusers, who have not progressed from marijuana to alcohol, initially began with alcohol for purposes of a "high" which could be secured on limited funds as opposed to the cost of a "high" from marijuana or LSD.

Dr. Frank Seixas of the National Council on Alcoholism also points out that in the U.S., alcohol consumption is associated with adulthood, and many more teenagers are becoming "adults" earlier due to the lowered voting age, a more open acceptance of sexual activity at an earlier age, entrance into military services in the teenage years, and an earlier menarche experience by girls. Dr. Chafetz states that there is now statistical confirmation that "the switch is on among young people from a wide range of other drugs to alcohol."

NIAAA is funding various innovative approaches in the treatment of the teenage alcoholic. As Blakeslee and Sullivan have pointed out in *Alcohol: The Teen-Age Turn-On* (1975) peer group programs in which older youths serve as models exploring the concept of responsible alcohol use are being implemented under the support of NIAAA. Also being implemented with the funding of NIAAA are "Hot Line" programs which consist of a 24-hour phone service for teenage alcohol abusers who are in need of help and family oriented alcoholism-prevention workshops in which teenagers and their parents discuss familial interrelationships and methods by which decisions for living are made.

Elderly

The problem of alcoholism and the aged has been traditionally ignored. The myth that alcohol problems decline or even disappear with age has been perpetuated. Too, those professional and lay workers in the field of alcoholism who did at least acknowledge the problem, customarily pointed to the fact that alcohol abuse was not as widespread among the elderly as among the young. Thus, treatment programs were never funded and seldom considered.

Most professionals presently in the geriatric field are now recognizing that alcoholism among the elderly is a grave problem. James Isbister, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration points to the fact that the aged are vulnerable and cites numerous factors contributing to their alcohol abuse: 1) loss of occupation; 2) high incidence of poverty; 3) significant isolation and loneliness; 4) increased susceptibility to debilitating physical disease; 5) loss of status and sense of uselessness in a youth-oriented society; 6) changes in living arrangements, and 7) personal losses.

Leon Epstein states in "Alcoholism, Drug Abuse, and Antisocial Behavior" (1972) that antisocial behavior in the aged, measured by arrests, seems to be more closely related to alcohol abuse than to chronic brain syndromes or sexual deficiencies as has been traditionally thought. Epstein observes several basic factors related to alcohol abuse and the elderly;

1. Alcoholics constitute a substantial group among the elderly mentally ill, especially those who are hospitalized.
2. Elderly alcoholics generally fall into two categories: those who have been alcoholics for many years and those who have become so after 60 years of age.
3. Clinical experience suggests that most elderly alcoholics showed some evidence of alcohol addiction at earlier ages, even though their actual alcoholism may have appeared only after age 60.

Dr. Epstein points to the fact that:

> while advancing age decreases the general population's proportion of alcoholics, the social and medical implications of alcoholism in the elderly will achieve greater significance with the growing number of older people.

Sadly, federally funded programs still rarely see the aged as patients.

Summary

It is important to note the lack of research data available concerning alcohol abuse among minority populations. Alcohol abuse and alcoholism are grave problems for minorities. It is rather paradoxical that such an "epidemic" health problem for such a large population has been suppressed and ignored, while the general problem of alcoholsm has received more attention within the last year than in the previous ten years.

Unique Needs and Concerns

As has been suggested earlier, alcoholic minorities have had very few services available to them. With the exception of public hospitals which could offer only medical help, treatment on a long-term basis and rehabilitation services were oriented toward the white middle-class male. Even Alcoholics Anonymous has had little impact on minorities due to its middle-class white male orientation.

A basic and outstanding need for all minorities is *specialized* programs including various treatment modalities that have been developed out of an understanding of differences in drinking patterns characteristic of a particular minority group and a further comprehension of this group's psychosocial situation. For example, a program especially developed for Indians must evolve out of a basic understanding of the Indians impassivity in novel settings, his tendency toward psychosocial nomadism and his reluctance to see alcohol as a potential problem. Programs geared toward the poor urban black must take into account the problems indigenous to the Black ghetto dweller, with emphasis on the fact that such problems cannot be handled as separate but must be approached in what Bourne (1973) calls "a global manner in which is taken into account a wide range of ultimately linked problems of which alcoholism is frequently only one..

A further need lies in the area of educating both the professional and lay public in terms of their knowledge of minorities and also in their acceptance of these populations. Some research has indicated less willingness to work with minorities than with the white middle-class community among health workers and crisis intervention personnel. Thus, referrals from agencies to hospitals for more intensive medical help are often less frequent for minorities than for the white middle class.

Vitols (1968) in comparing the drinking patterns of Negro and white alcoholics admitted to a state facility in North Carolina noted that Black alcoholics were referred significantly less often than white alcoholics despite the high prevalence of alcoholism in the surrounding Black communities. Education of the health workers and counselors is, however, difficult without adequate research in the area of alcoholic minorities.

Those research studies that have been done and the resulting generalizations concerning alcoholic minorities indicate a serious lack of basic data. As Kinsey (1966) points out, much of the research concerning unique aspects of female alcoholism is limited and extracted from selected samples, most of which have not undergone empirical examination.

Finally, a need which appears mandatory is further Federal intervention in an effort to deal effectively with the problem of alcoholism and minorities through Federally supported programs. Such programs would make funds available for the treatment of medical and social problems in minority populations.

Treament Programs for Minority Populations

Those programs which appear most significant in the treatment of minority populations are often community-based with an emphasis on the pragmatic and culturally relevant approach to alcoholism.

Staff are often former alcoholics and representative of the particular minority served and fill such positions as director, volunteer workers, and program participants. A part-time physician is usually employed. There is usually a cooperative agreement between the community facility and other supportive agencies, and the program is commonly one of comprehensive rehabilitation including four major phases: recruitments, support, productivity, and involvement of the community. The recruitment phase usually entails outreach, initial evaluation, and orientation. Support is usually given through counseling services as the alcoholic progresses through detoxification. During this time the client is also exposed to vocational guidance with an emphasis placed on the client's developing career goals and objectives. Productivity entails the client's returning to the world of work where he may be in training or re-training. Close follow-up through out-patient programs is considered as a necessity at this point. The fourth phase, community involvement, places emphasis on the client's readjustment to his familial/peer community through participation in those activities aimed at services for the alcoholic.

These programs have generally been handled through community mental health programs or programs established by the Office of Economic Opportunity; re-emphasis must be given to the fact that these programs are for the most part staffed by para-professionals rather than by highly trained community mental health workers. Bourne (1973) illustrates this community-based concept by discussing a program started in Atlanta by OEO in which all staff members are former alcoholics and clients for the most part are urban Blacks. The program has three components: a small in-patient unit for detoxification, a twenty-bed half-way house, and an out-patient counseling program. He points out that with the exception of the in-patient unit, all other aspects of the program are operated by recovered alcoholics who are almost always representative of a minority population.

All programs for minority populations stress the importance of some type of detoxification unit so as to remove the alcoholic from a milieu that is supportive of his alcohol abuse. Usually this detoxification lasts no longer than five days. The out-patient program is specifically geared toward meeting individual needs and concentrating on pride in the client's particular culture and in his own identity. In discussing out-patient programs for minorities Bourne (1973) states:

> The counselors, being recovered alcoholics from the same environment, serve not only as effective role models, but are also able to provide therapy which is predominantly directive and reality oriented yet plausible and acceptable to the client.

The concept of segregated treatment programs for minorities appears to be an effective method in reaching a specific minority population and in the maintenance of a program for the clients.

Preventive Measures

Practical preventive measures are limited. However, the most basic of all preventive measures is education of the alcoholic as well as the general public. In a drug rehabilitation program in Puerto Rico, a program specifically oriented toward service to minorities, sponsored by the National Institute of Mental Health and Commonwealth funds, the primary objective is prevention through community education. The program was created to make the community aware of drug and alcohol problems with each member of society and not only with private or governmental groups. Voluntary group participation within the community is promoted with emphasis placed on the training of community groups in the most effective techniques and methods of combating the problem.

Many programs are now realizing the importance of establishing "prevention service centers" to help youth under the age of 18 avoid the susceptibility to alcohol. Such centers work closely with their respective neighborhoods and draw upon supportive agencies as resources. Primary objectives: 1) motivating the youth toward the establishment of career objectives; 2) improvement of the educational level of the youth; 3) encouraging an active sense of responsiblity through citizen involvement; and 4) replacement of the indicative negative attitudes often contributing to initial alcohol abuse.

There are other prevention programs geared toward the reduction of alcohol abuse through legal steps and through the use of less concentrated beverages. However, these programs are still theoretical with little emphasis placed on reality and pragmatism.

Research Findings

Possibly one of the most outstanding findings in present research on alcoholism and minorities is that the research itself is scarce and inadequate with many hypotheses left untested, resulting in too numerous generalizations and ensuing ethnocentric stereotyping. Research has, however, indicated some trends worth noting.

The World Dialogue on Alcohol and Drug Dependence in 1970 reported several trends in minorities which appear significant. The number of women alcoholics, usually cited in a ratio of one woman to five men, has changed to a ration of one woman to three men, suggesting a definite trend. Also, the number of alcoholics under age 20 is rapidly increasing, whereas prior to 1970 there were few evidenced.

Finally, the report indicated that the number of alcoholics over age 50 was sharply declining, as compared to the sharp rise among those under 50 years of age.

Kinsey (1966) in his report on the female alcoholic points out several findings. Disruptions in familial/marital relationships are highly correlated to the onset of alcoholism in the female, as is ambivalence toward fathers and feelings of hostility toward mothers. Too, Kinsey cites that female alcoholics tend to place themselves in relationships with men that are characterized by exploitation and violence and tend to manifest psychosexual maladjustments.

M.M. Glatt in *A Guide to Addiction and Its Treatment* (1974) has researched the etiology of adolescent alcoholism and notes that young alcoholics tend to be much more disturbed emotionally than the hypothetical average adult alcoholic. He suggests early emotional deprivation and insecurity may have started the drinking in order to provide the missing feelings of adequacy and acceptance.

REFERENCES

Black alcoholism [*Booklet*]. Atlanta: School of Social Work, Atlanta University, 1975.

Blakeslee, A. and Sullivan, B. *Alcohol: The teenage turn-on*. New York: The Associated Press, 1975.

Bourne, P.G. and Fox, R. (eds.). *Alcoholism*. New York and London: Oxford University Press, 1970.

Chafetz, M.E., Beane, H.T., and Hill, M.J. (eds.). *Frontiers of alcoholism*. Toronto: University of Toronto Press, 1968.

Epstein, L.J. Alcoholism, drug abuse, and antisocial behavior. *Geriatrics*, 1973, 45-59.

Forrest, G.G. *The diagnosis and treatment of alcoholism*. Springfield, Illinois: Charles C. Thomas, Publisher, 1974.

Glatt, M.M. *A guide to addiction and its treatment*. New York: Halstead Press, 1974.

Gospodarek, M. (speech) NCAE Conference on Women, Sexism, and Problem Drinking. North Conway Institute, June 17-20, 1975, North Conway, New Hampshire.

Harper, F.D. *Alcohol and blacks: an overview*. Alexandria, Virginia: Douglass Publishers, 1976.

Harper, F. and Dawkins, M. Alcohol and blacks: state of the periodical literature. *British Journal of Addiction*, 1976 (In press).

Karpman, B. *The alcoholic woman*. Washington: Linacre Press, 1956.

Kinsey, B.A. *The female alcoholic*. Springfield, Illinois: Charles C. Thomas Publishers, 1966.

Schmidt, W.R., Smart, G., and Moss, M.F. *Social class and the treatment of alcoholism*. Toronto: University of Toronto Press, 1968.

Vitols, M.M. Culture patterns of drinking in negro and white alcoholics. *Disorders of Nervous System*, 1968, 29, 391-394.

World Health Organization (Expert Committee on Alcohol: First Report. WHO Technical report Series, No. 84, Geneva.)

Zax, M., Gardner, E.A., and Hart, W.T. Public intoxication in Rochester. *Quarterly Journal of Studies on Alcohol,* 1964, 25, 669-678.

Chapter VI

REVIEW OF RESOURCES

The purpose of this chapter is to identify materials and resources available to the person who works with, or will train others to work with, minority groups. This chapter is divided into the following sections: books, periodicals, dissertations/unpublished materials, project reports/manuals, films, and organizations. An outline of the appropriate utilization of community resources follows the list of local-level organizations.

BOOKS

1. Akers, R.L. *Deviant behavior, a social learning approach.* Belmont, California: Wadsworth Publishing Company, 1973.
2. Ayars, A.L. and Milgram, G.G. *The teenager and alcohol.* New York: Richards Rosen, 1970.
3. Bahr, H.M. *Skid Row: An introduction to disaffiliation.* New York: Oxford University Press, 1973.
4. Bell, G. *Escape from addiction.* New York: McGraw-Hill, 1970
5. Bourne, P.G. and Fox, R. (eds.). *Alcoholism.* New York and London: Academic Press, 1973.
6. Cahalan, D. *Problem drinkers.* San Francisco; Jossey-Bass, 1970.
7. Cahn, S.*Treatment of alcoholism.* New York: Oxford University Press, 1970.
8. Carrol, C.R. *Alcohol: use, nonuse, and abuse.* New York: William C. Brown Company, 1970.
9. Catanzaro, R.J. (ed.). *Alcoholism: The total treatment approach.* Springfield, Illinois: Charles C. Thomas Publishers, 1968.
10. Chafetz, M.E. Blane, H.T., and Hill, M.J. (eds.) *Frontiers of alcoholism.* New York: Science House, 1970.
11. Cull, J.G. and Hardy, R.E. *Alcohol abuse and rehabilitation approaches.* Springfield, Illinois: Charles C. Thomas Publishers, 1974.
12. Cull, J.G. and Hardy, R.E. *Organization and administration of drug abuse treatment programs.* Springfield, Illinois: Charles C. Thomas Publishers, 1974.
13. Fort, J. *Alcohol, our biggest drug problem.* New York: McGraw-Hill, 1973.
14. Forrest, G.G. *The diagnosis and treatment of alcoholism.* Springfield, Illinois: Charles C. Thomas Publishers, 1975.
15. Frank, E.D., Juniel, A.L. and Shorty, V.J. *A situation of desire: the evaluation and implementation. In J.G. Cull and R.E. Hardy* [*eds.*], Organization and administration of drug abuse programs. Springfield, Illinois: Charles C. Thomas Publishers, 1974.
16. Glatt, M.M. *A guide to addiction and its treatment.* New York: Halstead Press, 1974.
17. Grad, F.P., Goldberg, A.L., and Shapiro, B.A. *Alcoholism and the law.* New York: Oceana Publications, 1971.
18. Harper, F.D. *Alcohol and blacks: An overview.* Alexandria, Virginia: Douglass Publishers, 1976.
19. Jellinek, E.M. *The disease concept of alcoholism.* New Haven: Hillhouse Press, 1960.
20. Jessor, S.L. *Society, personality, and deviant behavior.* New York: Holt, Rinehart-Winston, 1968.
21. Karpman, B. *The alcoholic woman.* Washington, Linacre Press, 1956.
22. Kinsey, B.A. *The female alcoholic.* Springfield, Illinois: Charles C. Thomas Publishers, 1966.
23. Larkins, J.K. *Alcohol and the negro: explosive issues.* Zebulon, North Carolina: Record Publishing Company, 1963.
24. Lemert, E.M. Socio-cultural research on drinking. In M. Keller and T.G. Coffee (eds.) *Twenty-eighth international congress on alcohol and alcoholism* [*Vol. 2*], Highland Park, New Jersey: Hill House Press, 1969.
25. Madsen, W. *The American alcoholic.* Springfield, Illinois: Charles C. Thomas Publishers, 1974.
26. Pittman, D.J., Snyder, C.R. (eds.). *Society, culture, and drinking patterns.* New York and London: John Wiley and Sons, Inc., 1967.
27. Plaut, T. *Alcohol problems: A report to the*

Nation. New York: Oxford University Press, 1967.

28. Rubington, E. and Weinberg, M. *The study of social problems*. New York: Oxford University Press, 1971.
29. Siegel, H.H. *Alcohol detoxification programs*. Springfield, Illinois: Charles C. Thomas Publishers, 1973.
30. Schmidt, W., Smart, R.G., Moss, M.K. *Social class and the treatment of alcoholism*. Toronto Press, 1968.
31. Tracy, D. *What you should know about alcoholism*. New York: Dodd, Mead, and Co., 1975.
32. Weisman, J. *Stations of the lost: Treatment of skid row alcoholics*. Inglewood Cliffs, New Jersey: Prentice-Hall, 1970.
33. Whitner, E.D. (ed.) *World dialogue on alcohol and drug dependence*. Boston: Beacon Press, 1970.

PERIODICALS

1. Affeldorf, M., and Hunley, P.J. Application of MMPI alcoholism scales to older alcoholics and problem drinkers. *Journal of Studies on Alcohol*, May 1975, 645-653.
2. Affeldorf, M., Hunley, P.J. and Cooper, G.D. Disciplinary problems in a home for older veterans: Some psychological aspects in relation to drinking behavior. *Gerontologist*, 1972, 12, 143-147.
3. Allen, F. A comprehensive military drug and alcohol program. *International Journal of the Additions*, 1974, 9, 137-144.
4. Ames, T.R. and Levy, J.M. The hostel, plans and purposes. *Journal of Rehabilitation*, 1973, 39, 28-30.
5. Barton, W.E. Deficits in the treatment of alcoholism and recommendations for correction. *American Journal of Psychiatry* 1968, 124, 1679-1686.
6. Carter, F.M. Personality factors and participation in treatment by hospitalized female alcoholics. *Psychiatric Quarterly Supplement*, 1966, 40, 72-80.
7. Freeman, H.W. and Scott, J.F. A critical review of alcohol education for adolescents. *Community Mental Health Journal*, 1966, 2, 220-230.
8. Heilburn, A.B. Prediction of rehabilitation outcome in chronic court-case alcoholics. *Quarterly Journal of Studies on Alcohol*, 1971, 32, 328, 333.
9. Henderson, N.B. Cross cultural action research: some limitations, advantages, and problems. *Journal of Social Psychology*, 1967, 73, 61-70.
10. Kline, J.A. and Roberts, A.C. A residential alcoholism treatment program for American Indians. *Quarterly Journal of Studies on Alcohol*, 1973, 34, 860-868.
11. Mackay, J.R., Phillips, D.L. and Bryce, F.O. Drinking behavior among teenagers: a comparison of institutionalized and non-institutionalized youth. *Journal of Health and Social Behavior*, 1967, 8, 46-54.
12. Manohar, V. Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, 34, 869-877.
13. Mayer, J. Treatment of the female alcoholic, the former prisoner. *American Journal of Orthopsychiatry*, 1968, 37, 932-937.
14. Moore, R.A. Alcoholism as a mental illness: implications for treatment and research. *Quarterly Journal of Studies on Alcohol*, 1968, 29, 172-175.
15. Robins, L.H. and Guze, S.B. Drinking practices and problems in urban ghetto populations. *Presented at Recent Advances in Studies of Alcoholism*, National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, Washington, D.C., 1970.
16. Shore, J.H., Bapp, J.F., Waller, T.R., and Daves, J.W. A suicidal prevention center on an Indian reservation. *American Journal of Psychiatry*, 1972, 128, 1086-1091.
17. U.S. Department of Health, Education, and Welfare. *First Special Report to Congress on Alcohol and Health*. Rosenberg, S., DHEW, Publication No. 1972-9099. Washington, D.C.: U.S. Government Printing Office, 1971.
18. Vitols, M.M. Culture patterns of drinking in

negro and white adolescents. *Disorders of Nervous System*, 1968, 29, 391-394.

19. Wilson, L.G. and Shore, J.H. Evaluation of a regional Indian alcohol program. *American Journal of Psychiatry*, 1975, 132, 255-258.
20. Zax, M., Gardner, E.A., and Hart, W.T. Public intoxication in Rochester. *Quarterly Journal of Studies on Alcohol*, 1964, 25, 669-678.
21. Zimberg, S., Lipscomb, H., and Davis, E.B. Sociopsychiatric treatment of alcoholism in an urban ghetto. *American Journal of Psychiatry*, 1971, 127, 106-110.

Dissertations/Unpublished Materials

1. Curlee, J.E. *A comparison of male and female patients at an alcoholism treatment center.* Unpublished doctoral dissertation, University of Minnesota, 1969.
2. Davis, H.G. *Variables associated with recovery in male and female alcoholics following hospitalization.* Unpublished doctoral dissertation, Texas Technological College, 1967.
3. McCabe, W.J. *The prediction and comparison of vocational rehabilitation outcome with two groups of alcoholic clients using a discrete discrimination analysis technique.* Unpublished doctoral dissertation, Florida State University, 1972.
4. Thomas, D. *A study of selected factors on successfully and unsuccessfully treated alcoholic women.* Unpublished doctoral dissertation, Michigan State University, 1971.

Project Reports/Manuals

1. Albert, J.M. Report on a treatment program for young addicts. *Toxicomanies*, 1972, 5, 77-98.
2. Beigel, A. Planning for the development of comprehensive community alcoholism services: assessing community awareness and attitudes, Southern Arizona Mental Health Center. *American Journal of Psychiatry*, 1974, 31, 1116-1121.
3. Hunt, G.M. and Azrin, N.H. A community-reinforcement approach to alcoholism, Anna State Hospital, Behavior Research Lab. *Behavior Research and Therapy*, Feb. 1973, 91-104.
4. Katz, L. The Salvation Army Men's Social Center results. *Quarterly Journal of Studies on Alcohol*, 1966, 27, 636-647.
5. McBride, J. Intermediate treatment services available for alcoholics at the Beckley Appalachian Regional Hospital, Morgantown, West Virginia.*Selected papers delivered at the Ninth Annual West Virginia School on Alcohol and Drug Abuse*, June 17-22, 1973.
6. Philadelphia Center House: Impatient treatment program for the pre-skid row man. *Alcohol, Health and Research World, 1973*, 1, 8-11.
7. Pickens, R., Bigelow, G., and Griffeths, R. An experimental approach to treating chronic alcoholism: a one year follow-up. *Behavior Research and Therapy*, 1973-11, 321-325.
8. Porter, T.L. (ed.). Rehabilitation of the alcoholic, a training guide. *Sixth Institute on Rehabilitation Services*, 1968.
9. Whittington, H.G. (ed.) Alcoholism in Denver, Denver department of Health and Hospital. *Development of an urban mental health center, 1973.*

Films

1. *A Time for Decision* — depicts problems of the compulsive drinker and his family in attaining a normal life.
2. *Alcohol and College Youth: Alcohol and Alcoholism* — a lecture on the theories covering teenage alcoholism.
3. *Alcohol and College Youth: Effects of U.S. Drinking Practices* — a lecture on guidelines for college policies in planning and enforcing drinking regulations.
4. *Alcohol and College Youth:* Socio-Cultural context of drinking behavior among adolescents.
5. *The Curious Habits of Man* —a discussion on the physiological aspects of effects of alcoholism.

STATE PROGRAM CONTACTS

The legislative mandate to provide a working plan for the provision of alcoholism services has been implemented in every state. Consultants and specialists in each state are capable of providing technical expertise in the development of a wide variety of services, encompassing community and local interest.

Alabama
Alabama State Alcoholism Program
145 Moulton Street
Montgomery, Alabama 36104
Telephone: (205) 265-2301 X-235

Alaska
Division of Family and Children's Services
Office of Alcoholism
Pouch HO5F
Juneau, Alaska 99801
Telephone: (907) 586-6201

Arizona
Community Programs
2500 East Van Buren Street
Phoenix, Arizona 85008
Telelphone: (602) 271-3438

Arkansas
Office on Alcohol Abuse and Alcoholism
1515 West 7th Street, Suite 202
Little Rock, Arkansas 72202
Telephone: (501) 371-2003

California
Office of Alcoholism
825-15th Street
Sacramento, California 95814
Telephone: (916) 445-1940

Colorado
Alcohol and Drug Abuse Division
4210 East 11th Avenue
Denver, Colorado 80220
Telephone: (303) 388-6111

Connecticut
Connecticut State Alcohol Council
90 Washington Street
Hartford, Connecticut 06115
Telephone: (203) 566-3464

Delaware
Bureau of Substance Abuse
Governor Bacon Health Center
Delaware City, Delaware 19706
Telephone: (302) 834-8850 & 8851

District of Columbia
Department of Human Resources
District Building
Washington, D.C. 20004
Telephone: (202) 629-5443

Florida
Mental Health Program Office
1309 Winewood Boulevard, Room 336
Tallahassee, Florida 32301
Telephone: (904) 488-9955

Guam
Drug and Alcohol Coordinator
Guam Memorial Hospital
Agana, Guam 96910

Georgia
Division of Mental Health
Acohol and Drug Abuse Section
618 Ponce De Leon Ave., N.E.
Atlanta, Georgia 30308
Telephone: (404) 894-4785

Hawaii
Substance Abuse Agency
1270 Queen Emma Street
Room 404
Honolulu, Hawaii 96813
Telephone: (808) 548-7655

Idaho
Bureau of Substance Abuse
700 W. State — Basement
Boise, Idaho 83720
Telephone: (208) 384-3920

Illinois
Department of Mental Health and Developmental Disabilities
Alcoholism Division
188 West Randolph St., Room 1900
Chicago, Illinois 60601
Telephone: (312) 793-2907

Indiana
Division of Addiction Services
Five Indiana Square
Indianapolis, Indiana 46204
Telephone: (317) 633-4477

Iowa
Division on Alcoholism
Lucas State Office Building
Des Moines, Iowa 50319
Telephone: (515) 281-5604

Kansas
Alcohol and Drug Abuse Section
535 Kansas Avenue, Room 1106
Topeka, Kansas 66603
Telephone: (913) 296-3991

Kentucky
Bureau for Health Services
275 East Main Street
Frankfort, Kentucky 40601
Telephone: (502) 564-3970

Louisiana
Bureau of Substance Abuse
200 Lafayette Street
Seventh Floor, Weber Building
Baton Rouge, Louisiana 70801
Telephone: (504) 389-2534

Maine
Bureau of Rehabilitation
Office of Alcoholism and Drug Abuse Prevention
32 Winthrop Street
Augusta, Maine 04330
Telephone: (207) 289-2781

Maryland
Division of Alcoholism Control
201 West Preston Street
Baltimore, Maryland 21201
Telephone: (301) 383-2782

Massachusetts
Division of Alcoholism
755 Boylston Street
Boston, Massachusetts 02116
Telephone: (617) 536-6983

Michigan
Office of Substance Abuse Services
3500 North Logan Street
Lansing, Michigan 48914
Telephone: (517) 373-8600

Minnesota
Chemical Dependency Program Division
Metro Square Building, Room 402
Saint Paul, Minnesota 55101
Telephone: (612) 296-4610

Mississippi
Division of Alcohol Abuse and Alcoholism
619 Robert E. Lee Office Building
Jackson, Mississippi 39201
Telephone: (601) 354-7031

Missouri
Division of Alcoholism and Drug Abuse
P.O. Box 687
2002 Missouri Boulevard
Jefferson City, Missouri 65101
Telephone: (314) 751-4122

Montana
Addictive Diseases Bueau
1539 11th Avenue
Helena, Montana 59601
Telephone: (406) 449-2827

Nebraska
Division on Alcoholism
Box 94728
Lincoln, Nebraska 68509
Telephone: (402) 471-2851

Nevada
Bureau of Alcohol and Drug Abuse
505 E. King Street, 5th Floor
Kinkead Building
Carson City, Nevada 89701
Telephone: (702) 885-4790

New Hampshire
Program on Alcohol and Drug Abuse
61 South Spring Street
Concord, New Hampshire 03301
Telelphone: (603) 271-3531

New Jersey
Alcohol, Narcotics, and Drug Abuse Unit
Division of Alcoholism
P.O. Box 1540, John Fitch Plaza
Trenton, New Jersey 08625
Telephone: (609) 292-8947

New Mexico
Division of Alcoholism
113 Washington Street
Santa Fe, New Mexico 87501
Telephone: (505) 827-3251

New York
Division of Alcoholism
44 Holland Avenue
Albany, New York 12208
Telephone: (518) 474-5417

North Carolina
Division of Mental Health Services
Alcohol and Drug Services
P.O. Box 26327
Raleigh, North Carolina 27611
Telephone: (919) 829-4670

North Dakota
Division of Alcoholism and Drug Abuse
909 Basin Avenue
Bismarck, North Dakota 58505
Telephone: (701) 224-2767

Ohio
Alcoholism unit
450 East Town Street
P.O. Box 118
Columbus, Ohio 43216
Telephone: (614) 466-3445

Oklahoma
Division of Alcoholism
408-A North Walnut Street
Oklahoma City, Oklahoma 73105
Telephone: (405) 521-2811

Oregon
Mental Health Division
Programs for Alcohol and Drug Problems
2570 Center Street, N.E.
Salem, Oregon 97310
Telephone: (503) 378-2163

Pennsylvania
Governor's Council on Drug and Alcohol Abuse
Office of the Governor
Commonwealth of Pennsylvania
2101 North Front Street
Harrisburg, Pennsylvania 17110
Telephone: (717) 787-9857

Puerto Rico
State Alcoholism Program
Box B-Y
Rio Piedras, Puerto Rico 00928
Telephone: (809) 763-7575

Rhode Island
Services for Alcoholics
The Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
Telephone: (401) 464-3291

American Samoa
Department of Health
Pago, Pago, American Samoa

South Carolina
South Carolina Commission on Alcohol and Drug Abuse
P.O. Box 4616, Landmark East
3700 Forest Drive, Suite 300
Columbia, South Carolina 29240
Telephone: (803) 758-2521

South Dakota
Division of Alcoholism
Office Building No. 2
State Capitol
Pierre, South Dakota 57501
Telephone: (605) 224-3146

Tennessee
Section on Alcohol and Drugs
Capitol Blvd. Building
226 Capitol Blvd.
Nashville, Tennessee 37219
Telephone: (615) 741-1921

Texas
Texas Commission on Alcoholism
809 Sam Houston State Office Bldg.
Austin, Texas 78701
Telephone: (512) 475-2577

Trust Territory of The Pacific Islands
Division of Mental Health
Saipan, Mariana Islands 96950

Utah
Division of Alcoholism and Drugs
554 South 300 East Street
Salt Lake City, Utah 8411
Telephone: (801) 533-6532

Vermont
Alcohol and Drug Abuse Division
81 River Street
Montpelier, Vermont 05602
Telephone: (802) 828-2721

Virginia
Division of Substance Abuse
Commissioner of Substance Abuse
Department of Mental Health and Mental Retardation
James Madison Building
109 Governor Building
Richmond, Virginia 23219
Telephone: (804) 786-3082

Virgin Islands
Mental Health Services
P.O. Box 1442
St. Thomas, U.S., Virgin Islands 00801
Telephone: (809) 774-0117

Washington
Office of Alcoholism
Mailstop 45-1
Olympia, Washington 98504
Telephone: (206) 753-5866

West Virginia
Division on Alcoholism and Drug Abuse
State Capitol
Charleston, West Virginia 25305
Telephone: (304) 348-3616

Wisconsin
Bureau of Alcoholism and Other Drug Abue
1 West Wilson Street
Madison, Wisconsin 53702
Telephone: (608) 266-3442

Wyoming
Mental Health and Mental Retardation Services
State Office Building
Cheyenne, Wyoming 82001
Telephone: (307) 777-7351

Organizations

National Level

1. National Institute on Alcohol Abuse and Alcoholism (NIAAA)
   5600 Fishers Lane
   Rockville, Maryland 20852
2. National Clearinghouse for Alcohol Information (NCAI)
   Box 2345
   Rockville, Maryland 20852
3. National Council on Alcoholism
   2 Park Avenue
   New York, New York 10016
4. Alcoholics Anonymous (AA)
   P.O. Box 459
   Grand Central Station
   New York, New York 10017
5. Al-Anon/Alateen
   P.O. Box 182
   Madison Square Station
   New York, New York, 10010
6. National Center for Alcohol Education
   Att: University Research Corporation (NIAAA)
   5600 Fishers Lane
   Rockville, Maryland 20852
7. Federal government levels in the Departments of: (Washington, D.C.)
   (a) Corrections
   (b) Employment Security
   (c) Mental Health
   (d) Health, Education and Welfare (HEW)
   (e) Transportation — Alcohol and Traffic Safety

Regional

Area Alcohol Education Training Programs, Inc., for South and Southeastern States: SAAETP; 776 Juniper Street, N.E.; Atlanta, GA 30308.

State Level

(1) Governor's Commission on Alcoholism
(2) Single State Authority Agencies
(3) State Advisory Boards
(4) State Governmental Departments of:
  (a) Corrections
  (b) Education — Division of Vocational Rehabilitation
  (c) Employment Security
  (d) Welfare

Local Level

(1) Al Anon
(2) Alateen
(3) Alcoholic Anonymous Chapters
(4) Alcohol Information Centers
(5) Churches/Civic Organizations
(6) City-County Courts
(7) College/Universities
(8) County Corrections Farms
(9) Employment Security
(10) Family Service
(11 Goodwill Industries
(12) Hope Houses/Missions
(13) Hospitals
(14) Mental Health Agencies
(15) Nurses
(16) Psychiatrists
(17) Organizations-Business and Industrial
(18) Residential Treatment Centers
(19) Salvation Army
(20) Schools
(21) Vocational Rehabilitation Agency
(22) Welfare Agencies
(23) YMCA
(24) YWCA

Community Resources

(The following outline was written by Paul L. Schwartz, Director, Social Welfare Division, Memphis State University, Memphis, Tennessee.)

I. Introduction

A. Community resources should be visualized as either:

(1) Ancillary and supportive to the central plan of work being done with the client (centrality), or

2. The specific source of treatment to which the alcohol program is a referring agent (loss of centrality).

B. Community resources are best employed under the following circumstances:

1. An effective and realistic assessment of the client's individual needs has been made, in a psycho-social framework.
2. A realistic plan of service has been formulated by client and counselor, which incorporates specific achieveable goals.
3. Community resources have been identified which can contribute to the achievement of these goals.
4. There is a reasonable level of collaboration between client and counselor.

II. Community resources should be regarded as programs and services which the counselor can mobilize on behalf of clients. Three types may be discussed:

A. Formal, structured agencies

B. Informal, non-agency groups and individuals.

C. Supportive persons and groups in the client's own social world.

III. Formal Agency structures: these can be described as governmental and voluntary organizations which have stated service purposes, continuity and staffs of workers.

A. Many of these agencies are overloaded and understaffed and may have complex and bureaucratic intake and eligibility procedures. The problem of the counselor is often a problem of "penetration." Penetration may be described as the achievement of ready and useful acceptance of the client for service.

B. Many of these agencies may or may not do what they say they do. Counselors cannot afford to be wrong on this.

C. These agencies may do what they say they do, but do it badly. Counselors need to know the realities.

D. Some agencies may create sanctions against services to minority members.

1. Second-class service delivery
2. Cultural Attitude Blocks

E. Methods

1. Personal/informal contacts are superior to administrative/formal contacts; reaching the gate-keeper or the key person.
2. Use of client feedback
3. Active advocacy: objective should be long-term

F. Techniques for which to train

1. A "house list" which is shared with counselors, and which focuses on "what works"; constant updating of this list
2. "Show-and-tell" — experienced counselors taking trainees on agency visits to meet the persons who are the informal/personal gatekeepers
3. A liaison worker, whose central responsibility to the alcohol program is to find entries into agencies for the use of counselors
4. Use of in-service training sessions and staff meetings for sharing information
5. Forms of influencing positive connection: acknowledgements, "brownie points," honorial appointments, etc.
6. Time/effort component: is counselor allowed development time?
7. The formal/organizational approach — strengths and weaknesses; are offers of cooperation at top levels binding on lower levels?
8. Active, formal advocacy: attack, complain, use of media, use of law, etc. etc.

IV. Informal, non-agency groups and individuals

A. Exploration and identification of such resources requires specifically allocated time and effort.

B. The goal is to motivate and interest such resources, since they have no mandate to cooperate.

C. Minority-oriented community persons and groups are primary targets.

D. The effective use of boards-advisory committees can be employed in this area; all such work may not be done by professional counselor staffs.

E. Specific tasks must be identified, and resources sought for these; "sign up to help us" may be an ineffective approach.

F. Methods

1. Develop list of tasks needed to assist program.
2. Identify target groups and individuals for these tasks.
3. The best approach is through a peer, not through an unknown professional.
4. The best peers are persons of influence in groups or organizations; the idea of "chain-reaction."
5. Some beginning resources for target list creation
    a. Minority-oriented organizations and leaders
    b. Chamber of commerce, yellow pages, etc.
    c. University and college programs which have intern placements
    d. Church and civic groups; professional groups
    e. Use of speakers' bureaus: problems of skill, appropriateness and follow-up.
    f. The "peer grapevine"
    g. The advisory committee

V. Resources in client's personal and social world

A. This is case-oriented, not organization-oriented; it relates to relevant persons and groups in the client's relational system who can be motivated to support the client.

B. Client permission is an ethical requirement.

C. Seeing the client in his system context; identifying the positive supports

1. Relevant family
2. Friends
3. Minority-oriented groups
4. Other relevant systems: school, church, employment.

D. These resources are useful only when client is willing and able to share effort, on top of the table.

E. These resources are most useful when they deal with present support, not with past failures; the key is potentially *positive* influences, not formal ones; the daughter may be more useful than the wife, the friend more useful than the minister, etc.

F. Methods

1. Sensitization of counselors to the client's relational system
2. Raising counselor awareness of potential supports in the relational system
3. Open discussion with client by counselor

G. Techniques

1. Agency records which get at the relational component
2. Staff case reviews which accentuate this component
3. Use of consultants by skill, not necessarily by training

Chapter VII

PUBLIC RELATIONS

Public relations is the planned effort to influence opinion and action through socially responsible performance based on mutually satisfactory two-way communication. The essentiality of public relations is beyond debate in a society bound together by interdependence and swift communications yet split by recurring crises of change and confrontation.

Some of the public relations services that you may be responsible for concerning alcohol abuse programs within your area are: news releases, speeches to other agencies and organizations, community relations, product or behavioral change publicity, special events, miscellaneous manuals and leaflets, annual reports of your caseload, external publications, fund-raising campaigns, and training programs.

A public enterprise to prosper and endure must: 1) accept the obligations of public responsibility imposed by an increasingly interdependent society; 2) find ways of communicating with unseen, remote publics over lines lengthened and distended by physical distance and psychological difference, and complicated by multiplying barriers to communication; and 3) find ways of achieving integration into the total community that the organization was created to serve.

The public relations process has four basic steps: 1) research listening — involves probing the options, attitudes, and reactions of persons concerned with acts, policies, and guidelines of a special program or project; 2) decision-making — involves bringing these attitudes, opinions, ideas, and reactions to bear on the special alcohol program of an organization to enable the institution to chart a course of direction in the interests of all concerned; 3) communication and action — involves dramatizing the chosen course to all those who may be affected and whose support is essential; and 4) evaluation — involves evaluating the results of the program and the effectiveness of techniques used. Each of these steps is as important as the others. Each one is vital to an effective program. Too often there is too little research, too little planning, and too much publicity. Emphasis on fact-finding and planning largely distinguishes public relations from straight publicity.

Tools of Communication

William Werner states that while the mechanical means of communication have their important places, they are adjuncts and none of them can take the place of person-to-person contact. In your work with alcohol abuse programs, you will utilize the printed word, the spoken word, and the image. You will, therefore, use three avenues — personal contact, controlled media, and public media.

In this section we will examine several tools of communication. Their content can be controlled by the communicator at the point of origin; their impact depends upon your skill of communication.

Training Program Publication

Because of its versatility the training program or house publication has developed into a major medium. It meets the common need of both staff and trainees to tell their stories on paper, in their own words and in their own way, without being interrupted. Some of the guidelines or principles that should be followed:

1. The publication should fill the needs of the organization, trainers, and trainees.
2. It should provide useful, meaningful information, not small talk.
3. If distributed externally, it should go to group leaders of the community involved in alcohol abuse programs, as well as to the prospects for the training program.
4. It requires the joint interest and effort of supervisors and you as the editor.

Handbooks, Manuals and Books

There are two general types of booklets and pamphlets. 1) *Introduction Booklets* welcome the new trainee or visitor. They explain the rules, guidelines, and benefits of the alcohol abuse training program 2) ***Brochures*** on training have subject matter devoted to selling an idea or philosophy or to presenting the total entity rather than a single service. Basic questions to be considered: a) Does the type of book under consideration fit the institution's need or overall program? b) Will the nature and purpose of the book attract directly the persons involved in alcohol abuse training programs? and c) Does it further the institution's basic public relations objectives?

Letters and Bulletins

Individually written, individually addressed letters have long constituted the backbone of inter-organizational communication. Printed letters are being used in increasing volume to establish a direct, speedy line of communication with specific publics. Such letters should be: 1) inexpensive, 2) direct, 3) important-looking, 4) intimate, 5) quick, 6) informal.

Bulletin Board-Posters-Billboards

The bulletin board gets regular attention if kept current and interesting. It needs to be serviced often so that the news on it does not get stale. Messages should be brief. Posters are beneficial assuming that the messages are personalized and appropriate to the audience. To keep posters from growing stale, one good system is to start with a series of them in various locations, rotating them regularly among the several stations.

Information Racks

The information rack is used primarily for morale and trainee education. As booklets, pamphlets, magazines, books, and manuals become available through the National Clearinghouse for Alcohol Information (NCALI) or National Council on Alcoholism, they can be placed in the racks for the trainee or other interested persons to obtain and read.

Institutional Advertising

The one certain way to get publicity printed or broadcast is to buy space or time to use advertising. If you are a public or even private organization providing a public service, then you can use public service advertising at reduced rates or even free of charge. In order to prepare an effective advertisement, Hill and Knowlton have formulated these guides: 1) be frank, fair, and honest; 2) tell your story directly to an individual in his own language; 3) don't talk up or down to anyone; 4) use simple, unvarnished words and facts so that every person in the community will understand and believe what you have to say; 5) tell one story at a time — don't overload your copy; and 6) use figures sparingly —only then illustrated by simple examples.

Meetings

Meetings bring people together, face to face. This not only provides an opportunity to communicate to a selected audience, but also provides opportunity to listen. The carefully staged meeting results in two-way communication. In order for the meetings to be effective, a purpose, careful planning and staging, and skilled direction are required.

Staging such meetings will often be your task, especially when forming training groups. There are several check points: 1) comfortable and easily accessible facilities; 2) "breaks" in the middle of long sessions; 3) exhibits, displays, charts, graphs, and films or other playbacks wherever suitable to the subject matter; 4) refreshments if participants give up their spare time; 5) an opportunity for everyone to get into the act even if it is only through a note and a pen; and 6) press notice of the occasion with credit to people who were responsible for it.

Telephone Newslines and Public Address Systems

The telephone is an important way to confirm with individuals their commitment to your training. Also, it is a terrific way to communicate short authentic answers and post specific questions. It is important to construct a telephone list of key people affecting or contributing to the program. The Public Address System (PA) is often used in conjunction with a recorded music service to reach people effectively within organizations or institutions.

The Grapevine

The grapevine is not a formal tool of communication, but it is an effective one. You should stay tuned in on the grapevine in order to squelch harmful gossip or rumors by release of full facts.

Motion Pictures and Slide Films

Sponsored films are those conceived within and commissioned by a business, government agency or non-profit organization as an investment in communication for a sales, training or public relations purpose. They are paid for by the sponsor not with the intent of reaping direct monetary return from the showings but in the hope of developing ideas, motivations, attitudes, or reactions in the viewing audience.

Television provided the greatest impetus to the use of audio visuals, particularly sponsored films and slide films, because it began to develop a generation of people more open to receiving impressions and forming opinions from audio-visual media than the printed word. Television also pointed the way toward pictorial teaching (educational TV) and closed circuit TV classes.

The communications strengths of the motion picture are readily apparent: 1) it combines the impact of sight, sound, drama, color, and music with group enthusiasm; 2) it can present certain meanings involving motion which cannot be described as effectively by print or audio means; 2) it attracts sustained, exclusive attention to a message for the length of the showing; 4) it clarifies the time factor in any operation or series of events; 5) it provides a reproduced record of events; 6) it presents processes that cannot ordinarily be seen by the human eye; 7) it can bring the past and the distant to the viewer; 8) it can enlarge or reduce objects and can use cartoons to dramatize abstractions; 9) above all, it lets the viewer see with his own eyes and enforces the conviction that "seeing is believing."

In many cases, film is the one medium which reaches masses of underprivileged people in a way they understand, given their limited reading.

If it has been decided that you and your organization are going to produce a film on alcohol abuse, treatment, or prevention, these questions should be considered:

1. Why is the film being made or for what purpose?
2. What special audiences to you want to reach with it?
3. How long should it be to stand the best possible chance for exposure to the desired audiences?
4. What budget should be planned for production and effective distribution?
5. How much commercialism should the film include, if any?
6. Are you sure its excellence will be sufficient to successfully compete with TV shows and feature movies?

Closed Circuit and Cable Television

This tool, developed as a by-product of commercial TV, offers great potential. By means of a closed circuit, leased through A.T. & T., live pictures and sound can be piped from an originating point to one or more receiving locations across the country for viewing by selected audiences. Many institutions use it for training purposes.

Displays and Exhibits

In almost every business or institution there is a reception room, showroom, or lunch area. These places are natural areas for displays and exhibits. In addition to stationary or permanent displays, there are temporary exhibits in the community to mark a special event. Exhibit users should remember that the objective is "to captivate the foot-store visitor: 1) to stop in front of the display; 2) to remain long enough to look at the material; and 3) to be stimulated to immediate or future action."

Events

Techniques for planning and staging events have become quite elaborate. Clever invitations, special transportation, celebrities, souvenirs, exhibits, motion pictures, and refreshments figure among the enticements. In the community, *an open house* is a good story of civic spirit that the press welcomes. When prominent citizens drop in, then a photograph for the newspapers is in order.

Alcohol Abuse Agencies

The agencies involved in alcohol abuse and alcoholism programs must gear their public relations programs to educating the public to accept enlightened social concepts in fields such as mental health, problems of the aging, welfare programs, and even crime correction. Planned consistent programs are required to break the barriers of public apathy, superstition, and even mistrust.

Foremost among the problems facing health agencies is that of building communications with the minority populations. The National Public Relations Council of Health and Welfare Services, under the leadership of Harold Weiner, has developed a plan to improve relationships and communications between social agencies and inner-city residents, which was adapted to minority populations for use in the manual.

1. *Why New Efforts Are Needed*

A. "Come-and-get-it" services fail to reach the minority populations adequately.

(1) Minority populations' social disabilities and rates of mortality and morbidity from alcohol abuse are far higher than they are for the middle-class white male population.

(2) Most agencies lack service or information centers specifically for minority populations.

(3) Services that exist are frequently second-class or indirectly provided.

(4) Interests of the minority populations are still not directly represented on the board of directors or staff of most traditional agencies providing alcohol abuse and alcoholism programs.

(5) Uncoordinated "marketings" of agency services compound the difficulties to specific minority populations in obtaining needed services.

B. Traditional communication methods and messages rarely reach the minority populations.

(1) "Middle-class white male" mass media are unreliable routes to specific minority populations.

(2) Pamphlets and other traditional materials are largely created by persons not in touch with needs, interests, and language of the minority populations.

(3) Distribution of materials frequently stops short of the minority populations.

(4) Competition of messages from a host of agencies creates confusing static.

(5) Lack of involvement in specific minority's problems has estranged many established agencies from that segment of the community or society.

2. *What Kinds of Efforts can Alter The Situation?*

A. Coordinated approaches by individuals

(1) As aides, staff members, committee and board members

(2) As advisors on agency communications and communications to and from the minority populations

(3) As staff and volunteers in agency branch offices that deal directly with the minority populations

(4) As partners in developing training programs for specific minority populations for both civic leadership and for employment in the social agencies.

B. Coordinated approaches by groups of agencies

(1) Establishment of specific minority councils that deal with alcohol abuse and alcoholism programs which are staffed by individuals from the specific minority populations.

(2) Creation of "supermarkets" of services and information to make available one-stop centers in the nieghborhoods of the minority populations

(3) Reallocation of agency services and budgets to make sufficient resources available to coordinated enterprises

(4) Development of coordinated social action programs by groups of agencies to help fill expressed needs of the minority populations

C. Use of varied communication methods

(1) Work through organizations and institutions that deal directly with minority populations

(2) Enlist paid and volunteer workers from minority populations to help shape and deliver agency messages

(3) Reallocate agency public relations budgets to defray costs of communication research in minority populations

(4) Allocate public relations resources to joining communication action with other agencies.

(5) Use black, Spanish-oriented, Indian, and any other specific type of minority media.

More effective communication with the minority populations is imperative for alcohol abuse programs and agencies. There is a growing public impatience with all inflexible, bureaucratic, and impersonal enterprises. There is increased demand for straight talk and direct communications of these agencies to the minority populations.

REFERENCES

Cutlip, S.M. and Center, A.H. *Effective public relations.* Englewood Cliffs, New Jersey: Prentice Hall, 1971.

Fang, I.E. *Television news.* New York: Hastings House, 1968.

Schmidt, F. and Weiner, H.N. *Public relations in health and welfare.* New York: Columbia University Press, 1966.

Schoenfeld, C. *Publicity media and methods.* New York: MacMillan Company, 1963.

Stamper, A.D. "Public service time — an opportunity for PR." *Public Relations Journal.* 25, October, 1969.

Chapter VIII

VOCATIONAL REHABILITATION

"Rehabilitation" is conventionally defined as the process by which the individual suffering from alcohol involvement is helped to reduce his dependency upon alcohol so that he can raise his level of functioning in psychological, social, and *vocational* areas. Perhaps, then, rehabilitation can be considered the most difficult and yet the most potent aspect of the treatment of the alcoholic. Certainly, it has been found that alcoholics who have chosen sobriety can be very productive and contributing citizens in society.

Not all alcoholics drink heavily throughout their lives. There are periods when some of these alcohol-dependent individuals reduce their consumption. Such a fact carries definite implications for rehabilitation and emphasizes the importance of the initial evaluation and planning phases. That is, a direct outreach program whereby the alcoholic is given timely assistance in setting feasible goals during his period of alcohol restraint, might possibly be the most viable and successful treatment modality.

Evaluation

The Rehabilitation Act of 1973 stipulates several guidelines in the evaluation of an alcoholic prior to the actual planning and implementation of rehabilitation services. Federal regulations state that in order to determine whether any individual is eligible for vocational rehabilitation services, there shall be a preliminary study which shall be sufficient to determine:

> 1. Whether the individual has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment;
> 2. Whether vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability, or whether an extended evaluation of rehabilitation potential is necessary to make such a determination. (Sec. 401.34).

These federal guidelines, therefore, suggest that evaluation of the alcoholic entails a complete and thorough diagnostic study to determine if actual rehabilitation potential does, in fact, exist. If potential is determined, then other kinds of evaluation become necessary to achieve rehabilitation.

Porter (1968) suggests the following basic questions and areas of examination in the evaluation of an alcoholic:

1. What are the tools being established for the applicant? Gainful employment is obviously an important aspect in the discussion of *vocational rehabilitation* for the client and should be considered a primary goal. However, counselors working with alcoholics differ considerably on what changes must occur in the alcoholic's life for him to successfully meet this primary goal of vocational rehabilitation. Some counselors feel that complete abstinence from alcohol for the rest of the alcoholic's life is necessary. Consequently, many potentially productive alcoholics are "screened out." However, if a counselor is willing to become less rigid in his expectations, perhaps a significantly larger population of alcoholics can meet their individual potential.

   Porter cites minimum expectations for the counselor in evaluating the alcoholic for rehabilitation services:

   A. *Sobriety*, marked by commitment of the individual to acknowledge and deal as well as he can with his alcoholism.

   B. *Involvement with a continuing "support group,"* such as AA, church groups, etc. Such support systems can give the necessary encouragement and strokes both during the struggle and afterwards.

   C. *Return to gainful employment.*

2. What treatment and rehabilitation resources, both institutional and personal, are available for use by the counselor and client? There has been an increase in the number and variety of

treatment programs available. However, cooperative efforts between vocational rehabilitation agencies and existing treatment programs can be very beneficial in providing a total alcohol rehabilitation program.

Personal resources of the counselor might include the following characteristics:

A. Desire or willingness to work with alcoholics.

B. Patience in the face of slow, uncertain or erratic progress on the client's part.

C. Willingness to fail and allow the client to fail.

D. Ability to examine himself and be aware of his own emotional needs and defenses, and how these can affect the counseling relationship with the client.

E. Ability to tolerate ambiguity.

In determining vocational rehabilitation potential various types of tests can be helpful to both counselor and client. Often the counselor is unable to identify specific aptitudes, dexterity, coordination, etc., through work samples or on-the-job evaluation. Psychological tests, vocational interest surveys of aptitude, and personality and adjustment tests can provide both client and counselor with valuable and realistic information about the client that will be conducive to achievable goals.

Further methods of evaluating vocational potential might entail work sample prorams. Such programs often add clarification and exploration of a client's potential through the actual placement of the client in a simulated work setting.

(The main avenue for information concerning vocational evaluation is: Materials Development Center; Department of Rehabilitation and Manpower Services; University of Wisconsin-Stout; Menomonie, Wisconsin 54751.)

Tools Used in Evaluation or Assessment

The following is a list and brief description of certain tools for assessing the rehabilitation potential of the alcoholic individual. The tests involve the evaluation of specific characteristics of the client that the agency or institution is trying to identify. The psychological tests include reading and vocabulary, vocational interest surveys, general ability, intelligence, aptitude, achievement, personality, and adjustment.

Reading and Vocabulary. One of the most important rules in testing is to determine the reading level of the client and then select subsequent tests to conform to the client's reading level.

(1) *Gates-McGinitie Reading Test* — Explores vocabulary, speed and accuracy, and comprehension. Most frequently used reading test in vocational evaluation programs (Teachers College Press, Teachers College, Columbia University, New York, New York).

(2) *Gray Oral Reading Test* — Provides an objective measure of growth in oral reading from early first grade to college, in addition to the diagnosis of reading difficulties (Bobbs Merrill Company, Indianapolis).

Vocational Interest Surveys. Vocational interest surveys provide the rehabilitation counselor with preliminary information to begin planning for the vocational goal, while also providing new insights to the client concerning the world of work.

(1) *Kuder General Interest Surveys* — Designed to measure preferences for five general kinds of social activities: (a) working with ideas; (b) being active in groups; (c) avoiding conflicts; (d) directing others, and (e) being in familiar and stable situations (Science Research Associates, Chicago).

(2) *Ohio Vocational Interest Survey* — Helps clients to understand their interests and relate them to the world of work. It is directly linked to the *Dictionary of Occupational Titles* through the data-people-things values for 114 worker trait groups (Ohio Testing Services, Columbus, Ohio).

(3) *Occupational Interest Inventory* — Measures basic occupational interests. It includes six fields of interest: personal-social, natural, mechanical, business, the arts, and the sciences; and three types of interests: verbal, manipulative, and computational. (California Test Bureau, Monterey, California).

(4) *Vocational Interest and Sophistication Assessment Survey [VISA]* — Designed especially for mentally retarded. The male form provides interest and knowledge scores in garage, laundry, food service, maintenance, farm and grounds, and material handling. The female form provides scores in business and clerical, housekeeping, food services, laundry, and sewing.

General Ability Intelligence Tests. The intelligence tests have as their objective the assessing of the client's ability to learn or to solve new problems. The tests measure native ability.

(1) *Wechsler Adult Intelligence Scale* — requires a certified psychologist for administration and interpretation and is designed for use with individuals between the ages of 16-75. It consists of six verbal and five performance tests and is one of the most widely used clinical instruments (The Psychological Corp., New York).

(2) *Slosson Intelligence Test* — An individually administered oral test that is an excellent screening device. It is especially useful since it can be used with the blind, individuals with reading handicaps, the physically disabled, and those individuals who have difficulty working under the pressures of a timed test.

(3) *Army General Classification Test, First Civilian Edition* — Consists of vocabulary, arithmetic reasoning, and block-counting subtests and can be administered individually or in groups (Science Research Associates, inc., Chicago).

(4) *Otis Quick Scoring Mental Ability Test* — Yields a single I.Q. score and can be used to obtain a rough estimate of the client's general learning ability or can be used as a quick check to verify questionable test data. (Harcourt, Brace & World, Inc., New York).

(5) *Peabody Picture Vocabulary Test* — An individual intelligence test which provides an estimate of the client's verbal intelligence and can be administered to groups with reading problems, speech problems, mental retardation, or emotional withdrawal.

(6) *Revised Beta* — A non-verbal test of general learning ability for certain groups of the handicapped that cannot be tested through other traditional means.

Aptitude Tests. Aptitude tests focus on performance capabilities that have been developed without a conscious effort as opposed to achievement tests which attempt to measure the outcome of specific-training, education, and experience.

(1) *General Aptitude Test Battery* — measures nine aptitudes:

A. General Learning Ability
B. Verbal
C. Numerical
D. Spatial
E. Form Perception
F. Clerical Perception
G. Motor Coordination
H. Finger Dexterity
I. Manual Dexterity

(U.S. Employment Service, U.S. Dept. of Labor, Washington, D.C.)

(2) *Nonreading Aptitude Test Battery* — An adaptation of the General Aptitude Test Battery for non-readers. (U.S. Employment Service, U.S. Dept. of Labor, Washington).

(3) *Minnesota Clerical Test* — Measures the client's ability to notice differences between two items in a specified time period (The Psychological Corporation, New York).

(4) *Additional Aptitude Tests* —

A. *Crawford Small Parts Dexterity Test*
B. *Minnesota Rate of Manipulation Test*

C. *Pennsylvania Bi-manual*
D. *O'Connor Finger Dexterity*
E. *Purdue Pegboard*
F. *Stromberg Dexterity Test*
G. *Bennett Hand Tool Dexterity Test*

Achievement Tests. Designed to provide an evaluation of what an individual has learned from his education and experience.

(1) *Wide-Range Achievement Test* — Provides a rough indication of client's academic achievement. An oral section with each test is provided for the mentally retarded. Achievement factors identified include:

A. Reading
B. Spelling
C. Arithmetic

Personality and Adjustment Tests. Instruments for measuring personality and adjustment usually divided into two general classes: global and atomistic.

(1) *Vineland Social Maturity Scale* — Provides a systematic means of getting the necessary information about a client. Since the test is administered orally, it can be used with blind as well as non-readers but is predominantly used with the mentally retarded (American Guidance Services, Inc., Minneapolis).

(2) *Mooney Problem Check Lists* — A self-administered test which also can be administered orally for the blind. Aids clients to express their personal problems and facilitates the counselor-client communication process (The Psychological Corporation, New York).

(3) *Minnesota Counseling Inventory* — Measures family relationships, social relationships, and emotional stability factors, and assists the counselor in understanding the client's attempts to achieve self-understanding. (The Psychological Corporation, New York).

(4) *Edwards Personal Preference Schedule* — Provides a quick and convenient measure of fifteen personality variables: achievement, deference, order, exhibition, autonomy, affiliation, intraception, succorance, dominance, abasement, nuturance, change, endurance, heterosexuality, and aggression. (The Psychological Corporation, New York).

(5) *Sixteen Personality Factor Questionnaire [16PF]* — Identifies personality factors which are presented in a bi-polar format.

Test Resources. Additional information may be secured in the Buros Mental Measurement Yearbook published by Gryphon Press, 220 Montgomery Street, Highland Park, New Jersey 08904.

Planning

Evaluation attempts to answer the question, "What is the vocational potential of the client?" The planning phase attempts to answer "What needs to be accomplished for this client to meet his vocational potential?"

The most significant goal in the planning phase is meeting the needs of the client that have been identified during evaluation. Seldom can *one* agency alone meet these needs. A cooperative agreement among several agencies or support systems is often necessary to provide the client with those factors that will return him to the vocational world. The planning phase of the rehabilitation process is as individual as the client and differs vastly from client to client. However, certain services do make up a part of the planning phase and are worth noting at this point:

A. *Job Training* — to equip the client with those skills necessary for a specific job, usually one he has shown some potential for during evaluation.

B. *Work Conditioning and Pre-vocational Training* — to prepare the client for future work opportunities (i.e., job readiness).

C. *Exploration of Job Placement Possibilities* — or job development activities geared toward identification of those areas of work that might meet the needs of the client.

D. *Physical Restoration Services* — which could correct or minimize physiological deficits that hinder employability.

E. *Counseling or Psychological Services* — to provide the client with support, education, necessary confrontation, etc.

F. *Transportation* — which would assist the client in getting to his job.

G. *Social Services* — to help the client in dealing with social problems which might hinder his progress in vocational rehabilitation.

Referral Process

(Most of the information for this section came from a booklet, *The referral process*, developed by the Research and Training Center of West Virginia, and training manual, *An introduction to the vocational rehabilitation process*, by Drs. John F. McGowan and Thomas L. Porter.)

There is a specific need for adequate referral systems especially when rehabilitation agencies are interested in expanding and improving services to alcoholic individuals.

The referral process includes all the actions, efforts, skills or techniques that the alcoholic rehabilitation counselor uses to insure that potential alcoholic clients know about rehabilitation (especially vocational) and that the agency knows about the potential clients referred to them.

Definition and Classification of Referral

A referral is defined as any potential client who has applied or has been referred to an agency by letter, telephone, or other means and who presents sound need for, and interest in, rehabilitation services. The referral process is defined as the activites or tasks that are required to establish or maintain a flow of clients (referrals) both into the alcoholic rehabilitation agency and from the alcoholic counselor to other vocational agencies.

Referral Considerations

It is important when receiving referrals and referring clients to other agencies to consider the following:

(1) Every alcoholic individual is entitled to know about available vocational rehabilitation services and has the right to be considered for them according to his needs and interests.

(2) Suitable referrals should be based on a realistic understanding of the objectives and services the rehabilitation agency is equipped to provide.

(3) Referrals should be made at the earliest appropriate time when the alcoholic individual can actively participate in a rehabilitation program.

(4) A casefinding program needs to be active and comprehensive in order to keep referral channels open and referrals flowing both to and from all potential vocational sources.

(5) There should be a continual exchange of information from the alcoholic rehabilitation agency and the vocational agencies, and coordination of services to aid the alcoholic individual to the highest level of vocational functioning.

(6) The importance of receiving feedback from agencies referred to and referring agencies should be stressed. It is important to develop a public relations program in order that the public and other institutions can understand the part of particular agencies in the total rehabilitation of the alcoholic.

Efficiency and Development

To evaluate the efficiency of a referral system, three components of the referral process should be taken into consideration:

(1) The number and type of alcoholic individuals referred.

(2) The degree of the alcoholic individual's severity.

(3) The amount of time and effort spent to process the referral.

It is important for the person working with the alcoholic individual to develop a vocational rehabilitation plan with the client, and then consider through both present and previous contacts how the counselor can be of vocational support to the client, and whether training or direct job placement is indicated. It is also important to consider good community organization concerning a vocational plan.

Guides for Effective Casefinding

The alcoholic rehabilitation agency needs to develop its own referral sources and techniques for casefinding. The following are suggestions for effective casefinding:

(1) Maintain an open door policy for new referrals to the agency.

(2) Make periodic examination of sources and types of referrals to ascertain if they are coming from all the potential community resources.

(3) Make periodic contact with referral agencies both who refer and whom you refer clients to in order to learn of changes or new vocational programs to be implemented.

(4) Develop proper "feed-back" programs concerning referral to and from the agency.

(5) Give prompt attention to referrals.

(6) Maintain a record of referrals by date of referral, source, and action taken for evaluation and follow-up purposes.

(7) Provide for preliminary evaluation as basis for acceptance or rejection of referrals.

Source of Referrals

The majority of referrals to alcoholic rehabilitation agencies come from the following: (1) health agencies — public and private, general and special hospitals, clinics, mental institutions, physicians, public health service, and nursing groups; (2) employment and guidance agencies — public and private employment offices, and public and private counseling agencies such as B'nai B'rith, Urban League, and other voluntary religious, racial, and welfare units; (3) welfare agencies — public and private assistance and relief agencies such as Salvation Army, Catholic Charities, and state and city public welfare; (4) educational institutions — public, private, and denominational schools and colleges; (5) special interest groups — community groups formed to both prevent and educate the public to alcohol abuse and alcoholism; (6) civic service groups — YMCA, YWCA, Kiwanis, Optimist, etc., (7) insurance companies — state workmen's compensation board, Bureau of Old Age and Survivor's Insurance, and private and fraternal insurance companies; (8) religious groups — Protestant, Hebrew, and Catholic social and helping organizations; (9) employers, especially those who have alcoholic employees on their payroll who are good workers; (10) labor unions have a vested interest in alcoholic rehabilitation services and will often take an active role in rehabilitation of their members.

Additionally, the alcohol rehabilitation counselors will usually refer the alcoholic individual to the following sources or agencies concerning vocational rehabilitation services: (1) state vocational rehabilitation agency —assessement, training and job placement; (2) public and private technical schools — for vocational training; (3) volunteer training programs; (4) Goodwill Industries and Salvation Army — work adjustment programs including assessment and training; (5) public and private hospitals and physicians — rehabilitaton from both physiological and psychological approach as related to a comprehensive vocational rehabilitation program; (6) Employee Assistance Programs — found in major industries to counsel the alcoholic employee from a vocational standpoint; (7) labor unions — vocational training and counseling.

In summary, the supply of referrals to and from the social service agencies, businesses, and Labor Unions will be dependent upon how well these agencies and institutions have met the needs of the alcoholic individual who had been previously referred for rehabilitation. It should be kept in mind that there must be both inter-and intra-agency coöperation and coordination when considering the best possible rehabilitation program for the alcoholic individual. This may involve simultaneous rehabilitation programs from the physiological, psychological, and vocational areas in order to meet the multifaceted needs and concerns of the individual who has problems with alcohol.

Job Placement and follow-Up

It is the responsibility of most vocational rehabilitation agencies for placement of alcoholic individuals accepted for service. Not only are they responsible for the individual being suitably employed but also for follow-up services to assure that the vocational rehabilitation object is achieved.

McGowan and Porter (1967) stated that it usually falls upon the counselor to provide or arrange services that will enhance opportunities of clients in arriving at the best obtainable vocational ajdustment. Although in many cases, private or public employment agencies may directly accomplish job placement, it is still up to the alcoholic rehabilitation counselor to assure that adequate placement and follow-up services are provided to the alcoholic individual as part of the entire rehabilitation process.

Planning

An alcoholic individual who has been both physically and mentally restored, has accepted his disability, knows his assets and limitations, is adequately trained, but has not achieved a reasonable level of vocational adjustment, is not truly rehabilitated. Planning for job placement must begin in the early stages of contact with the client. Effective planning early in the vocational rehabilitation process prevents false starts in placement, motivates the client for employment, and involves clients directly in the establishment of ultimate goals of vocational adjustment. To be effective, a rehabilitation plan leading to job placement and involving follow-up must be developed by both the alcoholic-vocational rehabilitation counselor and the client. It is important that the alcoholic individual is committed to his plan.

Evaluation

It is important that an adequate evaluation of the alcoholic individual's medical, social, psychological, and vocational assets and liabilities precede the plan for placement and follow-up. Evaluation techniques and procedures must be as realistic and job-oriented as possible to secure maximum performance of the client.

Past performance is one of the best available indicators of future vocational behavior. The client should outline and analyze previous employment. He should list previous jobs, past employers, length of employment, reasons for terminations, and other pertinent data.

Pre-vocational evaluation is usually performed in rehabilitation centers or sheltered workshop settings. Duration of the evaluation may vary from a few days to several weeks depending on the individual client. Careful consideration must also be given to medical aspects of the client's condition, his mental outlook, his emotional adjustment, etc. The rehabilitation counselor should consider certain factors in the client's total personality such as: emotional stability, mental functioning, personal appearance, and general personality impressions. These are important factors in satisfactory vocational functioning.

Preparation

Adequate preparation of the alcoholic individual for employment includes some combination of the following:

1. Evaluation of the client's job readiness;
2. Guidance of the client in development and execution of a plan for job-seeking activities;
3. Instruction of the client in proper methods of making job applications, proper conduct and appearance during job interviews;
4. Contacting employers;
5. Registration of client with state employment service and other employment resources;

6. Analysis and modification of jobs;
7. Consultation with employers or supervisors who are advised and trained as required;
8. Provision for post-placement follow-ups involving others, where appropriate, such as vocational education, state employment service, public assistance or other public or private community agencies or organizations.

Counselor-Client Relationships

The counselor's role in the rehabilitation process is extremely important to success or failure of the rehabilitation plan. The counseling relationship serves to unify all the rehabilitation services into an organized plan resulting in an integrated experience. If the counselor is to assist the alcoholic individual, he must be able to help the client to determine his assets and liabilities, needs, and services necessary for rehabilitation.

The counselor must be able to help the client determine physical, psychological, occupational, and placement readiness. An appropriate counseling relationship mobilizes and activates the client's resources and also provides an opportunity for him to assume as many of the placement responsibilities as he is capable of assuming. Supportive counseling relationships are crucial when the alcoholic individual is in a final phase of training, seeking employment, for the first ten weeks after employment, and again when the rehabilitation counselor closes the case.

Follow-Up

The following purposes of follow-up, outlined in *Plancement Training Handbook* developed at San Francisco State College (1962), can serve as guides to counselors and others directly involved in this activity.

Client-Oriented

1. To determine whether vocational plan has been implemented;
2. To effect needed adjustments not anticipated;
3. To forestall the client's quitting his job without attempts at adjustment;
4. To help client anticipate adjustments that may become necessary;
5. To assist client in preparing for advancement ment on the job or in his field of work;
6. To provide any information client sees the need for;
7. To indicate counselor's continuing interest in client;
8. To determine whether counseling or training is necessary or desirable;
9. To determine whether a revised vocational plan is needed;
10. To forestall continuance of an undesirable placement;
11. To provide emotional support where needed;
12. To allow an opportunity for ventilation of feelings of discomfort;
13. To wean client from any dependency upon counselor or agency.

Employer-Oriented.

1. To evidence interest in employer's welfare;
2. To determine employer's satisfaction with client;
3. To provide consultation concerning client adjustment or performance progress;
4. To gain indications of the most suitable referrals to employer;
5. To determine employer's satisfaction with and suggestions regarding services.

Employee Assistance Program

(Information adapted for this section was received from Gerald Overton, founder and director of the Memphis, Tennessee Employee Assistance Program for the Metropolitan area.)

Employed alcoholic men and women are estimated to make up between 5 and 6 percent of the nation's overall work force and between 10 and 11 percent of the executives in industry. It is estimated that there are 4.5 million problem drinkers in business, industry, and government. The first company to see the importance of an employee assistance program was Consolidated Edison of New York in 1947. By 1971, over 300 companies had developed employee assistance programs for alcoholic individuals. Due to the stigma attached to the alcoholic individual within companies, programs were aimed at the multiplicity of behavioral problems that impair job performance. Most companies have developed policies and set up specific procedures to deal with the behavioral problem of alcohol abuse.

Program

In most industrial and governmental settings, alcoholic employees whose drinking has been identified are offered treatment at an earlier stage than unemployed drinkers. It is felt that chances for successful recovery are greatly increased because physical health has deteriorated less, financial resources are not completely depleted, emotional supports become readily available both by family and community, and strong motivation for recovery may be provided by implication of job loss. All of these factors contribute to a 50 to 70 percent recovery reported for successful Employee Assistance Programs. The following is a detailed summary of an Employee Assistance Program:

Phase One. Is an educational effort directed toward the top management and supervisory staff.

(1) This is the initial phase and is designed to aid management in detecting and providing proper assistance to the affected employee. An attitudinal change within Management is deemed important to detection and rehabilitation of the employee.

(2) This phase also involves, by a series of lectures and brochures, a concentrated attempt to motivate the employee toward seeking help for his disability and removing the stigma of detection.

3) This attempt to motivate and inform both employee and management is continued by a series of lectures and films given periodically through the year if desired.

Phase Two. Involves provision of treatment services

(1) The facilities of hospitals, clinics, treatment centers, and out-patient clinics are provided for the employee and his family referred by the program and other community agencies. This includes the following services:

a. Complete physical examination
b. Complete psychiatric evaluation
c. Comprehensive medical management of the acute and chronic pathophysiological sequel of alcohol and drug abuse.
d. Chemotherapy
e. Group therapy
f. Family therapy
g. Individual therapy

(2) The in-patient program is designed to give extensive care to the patient and rehabilitate him to the extent that he again becomes a productive member of society.

Phase Three. Begins simultaneously with Phase Two as follows:

(1) When the affected person is detected, a medical doctor, psychologist, or psychiatric social worker contacts him after the initial contact by the coordinator, supervisor, or labor representative and counsels him concerning his admittance to the rehabilitation program.

(2) As the employee relates to the treatment efforts, his coordinator, supervisor, or labor representative is counseled concerning the extent of rehabilitation for the employee and how best to deal with the individual.

(3) After the employee has returned to his job and family, he is expected to return regularly for counseling and re-evaluation by a doctor, therapist, or psychiatric social worker. Inclusion of the family members in the therapeutic structure is considered mandatory.

(4) The employee or his family members are informed that aid is always available to him at any time in the form of the doctor, therapist, or social worker who is responsible for his particular case.

(5) The employee is placed in an out-patient program which allows the doctor or therapist to make continual re-evaluation of the patient, and when more intensive care is indicated, management is notified of the situation. By this means, an employee is detected and prevented from again becoming a danger to himself and his employer or risking job loss.

REFERENCES

National Institute of Alcohol Abuse and Alcoholism. *Alcohol and alcoholism.* Washington, D.C.: United States Government Printing Office, 1972.

Overton, G. Employee Assistance Program. Paper presented at five-day workshop of the Memphis State University Alcohol Abuse Training Program, Memphis, Tennessee, 1976.

Porter, T.L. and McClary, J. *Rehabilitation of the Alcoholic.* (RSA No. 69-11) Washington, D.C.: Rehabilitation Services Administration, 1968.

McGowan, J. and Porter, T.L. *An introduction to the vocational rehabilitation process.* (RSA No. 68-32) Washington, D.C.: Rehabilitation Services Administration, 1967.

Research and Training Center. *Understanding the guidelines for the rehabilitation act of 1973.* (Social and Rehabilitation Services No. 451P-8108-3/3-01) West Virginia: Research Training Center, 1975.

Rusalein, H.S. and Malikin, D. *Contemporary vocational rehabilitation.* New York: New York University Press, 1976.

Chapter IX

LEGAL ASPECTS

Alcoholism has been traditionally an area of both legal and moral concern. As Kittrie has pointed out in *The Right to be Different* (1971), the influence of alcohol is constantly in the public eye and alcoholism has never been a condition enjoyed or suffered indoors. Out of 5½ million arrests for all crimes in the United States in one year alone, the FBI reports that 1.5 million are for public drunkenness, 307,000 for driving while intoxicated, 215,000 for other alcohol violations, and some 593,000 for disorderly conduct.

In considering that drunkenness accounts for one out of every three arrests and that after a detoxification stay in a jail many alcoholics are further processed through the judicial system and finally placed in a correctional institution for 30 to 120 days, it is quickly apparent that law enforcement agencies and other legal institutions assume an awesome task.

Too, as Hayman states in *Alcoholism: Mechanism and Management* (1966), the legal system has a special position since it is on the borderline between the social regulatory agencies and the individual regulatory agencies as illustrated below:

INFLUENCES ON THE CAREER OF THE ALCOHOLIC OFFENDER

	Individual
Social Regulatory Agencies	Family
	Peer Groups
	Marital Influences
	Educational Influences
	Religious Influences
	Organizations and Clubs
	Industrial Influences
	Liquor Controls
	Alcoholics Anonymous
	Skid Row Culture
	Law and Penal System
Individual Regulatory Agencies	Medical Treatment
	Psychiatric Treatment
	Welfare Agency
	"Foster Homes"
	Custodial Institution

From this theoretical viewpoint, therefore, the legal-penal system gains special consideration. Hayman (1966) suggests that when the alcoholic needs the law and penal system, this is evidence of a breakdown in the autonomy of the other regulatory systems. If such a breakdown does occur, the alcoholic offender is no longer protected nor influenced by these systems and is thus likely to come into conflict with the law.

The legal-penal systems encounter complexities in the ambivalence of societal mores and norms toward alcoholism. For example, alcohol abuse is considered both a crime and a contributing factor to the commission of crime. The legal system finds itself in another paradoxical position in that it has been forced into handling the problem of alcohol abuse and yet such a problem is now viewed primarily as a disease and not a social disorder.

The following areas of this chapter will continue to discuss these paradoxes, the historical evolution of the legal system as it applies to alcoholism, and existing government controls in an effort to examine progress, trends, and present needs of the law and the alcoholic offender.

Historical Perspective

(The following information is adapted from *Legal Control of Alcoholism: Toward a Public Health Concept* by P. B. Hutt.)

In discussing the historical evolution of the legal system and alcoholism perhaps some mention of the temperance movement is initially in order. Chafetz and Demone in *Alcoholism and Society* (1962) discuss the movement as occurring basically in three waves. The movement of 1870-1900 gave rise to the first mandate for legally required education regarding alcohol use. The second wave, occurring in the 1920's, was aimed at total abstinence and the complete elimination of the alcohol beverage industry. The third wave (1945 - present) placed emphasis on alcoholism treatment programs and alcoholism prevention endeavors of governmental public health movements.

Today all states have some type of law requiring that alcohol education be included in school curricula. Other nations are joining the United States in the acknowledgement that some type of law is necessary for the implementation of alcohol education programs. Germany, Hungary, Sweden, Great Britain, Uruguay, and Brazil are all active in this endeavor.

While traditionally the legal system has never displayed a tolerance toward alcohol abuse, under early English common law, public intoxication was not, in itself, a crime. It was classified as a sin against God and, therefore, within the realm of and punishable by ecclesiastical courts. However, by 1606 public intoxication was made a crime by a statutory law in England that was labelled "an act for repressing the odious and loathsome sin of drunkenness." In virtually every part of the United States public intoxication remains a criminal offense.

The first recognition of "chronic alcoholism" was made in 1675 by Lord Hale, who is now recognized as the first legal authority to undertake any significant analysis of the relationship between mental disease and the criminal law. He concluded that drunkenness would not excuse criminal activity except: (1) when it was caused by the "stratagem or fraud of another;" or (2) when long-continued drinking has resulted in an "habitual and fixed phrensy." From this early description of alcoholism evolved the court recognition of the commn law rule that "involuntary behavior" cannot be criminal and that "insanity" excuses what would otherwise be criminal conduct.

However, such judicial standards did not withstand time. In 1843 the M'Naghten's Case stipulated that a defense of "insanity" is warranted only when the defendant lacks the knowledge to differentiate between what is right and wrong. Such a stipulation is still the prevailing rule.

The conflict between the "involuntary behavior" definition and the "insanity" behavior has been traditionally difficult to discriminate and has endured inconsistent applications. In the State vs. Pike Case of 1869 a concentrated effort was made to examine such questions as: (1) Is alcoholism a disease? (2) Was the defendant suffering from alcoholism? (3) Was the crime a product of the defendant's alcoholism? The judge recognized that "when disease is the propelling, uncontrollable power, the man is as innocent as the weapon." However, such a decision stood alone for a century.

In 1966 two cases, *Easter vs. District of Columbia* and *Driver vs. Hinnat*, indicated a landmark in the merger of common-law doctrine and Constitutional command. *In Easter vs. District of Columbia*, the court held that the common law — conduct cannot be criminal unless it is "voluntary" — precludes conviction of an alcoholic for public intoxication. In *Driver vs. Hinnant* the court held that the conviction of a chronic alcoholic for public intoxication violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution.

In the case of *Powell vs. Texas*, 1967, an uneducated laborer earning $12 per week was arrested for public drunkenness, found guilty, and fined. (His record for public drunkenness was extensive.) The case was appealed to the U.S. Supreme Court since there was no other avenue of appeal within the state court system. The Supreme Court upheld the earlier rulings in the *Easter* and *Driver* cases that a derelict alcoholic cannot constitutionally be punished for public drunkenness. As was stated in the Senate Report on the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment,and Rehabilitation Act of 1970:

> . . . five of the nine Justices agreed that alcoholism is a disease, that an alcoholic drinks involuntarily as a result of his illness, and that an alcoholic who was either homeless or who could not confine his drunkenness to a private place for some other reason could not be convicted for his public intoxication. Powell's conviction was upheld by a 5-to-4 vote, however, because the record failed to show that he was homeless or otherwise unable to avoid public places when intoxicated.

Presently, the legal stipulation holds that a derelict alcoholic cannot be punished for his public intoxication.

Thus, such decisions placed emphasis on the requirement that the problem of the chronic alcoholic offender should be taken out of the courts and possibly has set the stage for a totally new concept in the treatment of the alcoholic.

Legislation

In August, 1965, President Lyndon Johnson initiated a review of the procedures implemented in dealing with intoxication and alcoholism under criminal law. Developing out this review were three drafting teams appointed to prepare model legislation which would govern intoxication and alcoholism. Three model or uniform legislations were developed. However, only the Uniform Alcoholism and Intoxication Treatment Act of the National Conference of Commissioners on Uniform State laws, occurring in 1971, still remains in effect. The following points reflect the major policy areas:

1. Alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.
2. An "alcoholic" is defined as a person who habitually lacks self control with respect to the use of alcoholic beverages or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic functioning is substantially disrupted.
3. A Division of Alcoholism was established with the powers and duties of the Division carefully specified. Included in these are the development of alcoholism plans and programs, coordination of resources, preparation of educational materials, development of training programs, sponsorship of research, maintenance of statistics, preparation of all state alcoholism treatment plans for funding pursuant to Federal legislation, fostering employee alcoholism programs, establishing highway safety alcoholism programs, encouraging general hospital and insurance programs to handle alcoholism problems, and submission of an annual report.
4. A State Interdepartmental Coordinating Committee and a Citizen's Advisory Council on Alcoholism were established with the requirement that a program for the treatment of intoxicated persons and alcoholics be established.
5. Authorization was given to the Division to establish rules and regulations for its treatment programs guided by priorities for voluntary rather than involuntary treatment and outpatient rather than impatient treatment.
6. A provision was established for the voluntary treatment of alcoholics.
7. A provision was established that intoxicated persons and those incapacitated by alcohol may be assisted to their homes or to treatment facilities by the police or emergency service patrols in protective custody under civil law.
8. Protection of the confidentiality of patient's records was established along with a provision for visitation and communications and the establishment of an emergency service patrol to replace the police in giving assistance to intoxicated individuals.
9. Political subdivisions were prohibited from adopting any law making public intoxication an offense or the subject of a sanction of any kind.

In 1971 the Secretary of Health, Education, and Welfare personally endorsed the Uniform Act and urged each state Governor to enact the act. The Uniform Act represents a major step forward.

Government and Legal Controls

There still exists controversy regarding the meaningfulness of government controls and alcoholism. Many feel governments can influence alcoholism in their individual states. They point to the fact that there are legal measures other than prohibition which can control and retard development of the chronic alcohol offender. Chafetz and Demone (1962) point to the following measures as significant: excessive taxes on all alcoholic beverages; limits on retail sales outlets; requirements that food must be purchased at the time alcohol is bought; variations in taxes (i.e., higher taxes on distilled spirits than on beer and wine, on the assumption that spirits cause more drunkenness); state-operated liquor stores (thus removing or controlling competition); controls on advertising; and a rationing system.

Some states today still control the sale of alcoholic beverages. Minors are denied the right to purchase and consume alcoholic beverages.

However, research indicates that such government controls have little to no effect on alcohol abuse. As Chafetz and Demone (1962) conjecture, legal controls are possibly more likely to affect the social drinker than the actual alcohol abuser. Substantiating such a hypothesis was the Moreland Commission's Study of the Liquor Control System of New York State which found that: (1) laws dealing with sales, sellers, and selling are irrelevant to the major problems of alcohol; (2) state monopolies on license systems are not important to the rates of drunken driving, to the number of first admissions for alcoholic problems or to alcoholism rates; (3) the number of package outlets has no relation to the consumption of alcoholic beverages; (4) no system of restrictive regulation of alcoholic beverages seems to encourage temperance; (5) the most crucial variable in high and low rates of incidence of alcoholism was the level of industrialization; and (6) consumption of alcoholic beverages is affected more by income levels and educational and cultural status than by cost.

Legal controls are also attacked as ambiguous and differing significantly from state to state. Lawmakers vary considerably in their respective states as to what in fact constitutes intoxication, the administration of penalties, and in the type of controls that are in effect. As Hayman (1966) points out, existing facts regarding the alcohol offender are so colored by prejudices and rationalizations that it is difficult to formulate a rational system of procedures and controls. For example, public drunkenness is considered an offense in some states when it is apparent that the accused has lost normal bodily and mental control, while in other states a manifestation of loudness and offensiveness can constitute intoxication. Too, some states consider a person with a blood alcohol level of 0.15 percent or more as legally intoxicated or "under the influence" while in other states the 0.10 percent level constitutes legal intoxication.

Criminal penalties for public drunkenness also differ from jurisdiction to jurisdiction. As Kittrie discusses in *The Right to be Different* (1971), an arrested individual in some states will be released under direction from the police station or legal institution upon posting a collateral of $10 to $20 which may be forfeited in lieu of an appearance in court. Those who appear before the courts may be fined or may receive a suspended sentence for the first offense, while subsequent offenses usually result in imprisonment ranging from two days to six months.

Penalties for "driving under the influence" are customarily more severe than for public intoxication, ranging from imprisonment for one year or longer to possible loss of driving privileges and heavy fines. The majority of states have a "negligent homicide" or "reckless homicide" statute with an accompanying penalty of five years in prison which is applicable when death is caused by negligent driving. As Kittrie (1971) states, however, these strict penalties are too infrequently exercised and it appears that often the streets have been much more thoroughly cleared of pedestrian alcoholics than the public roads of drunken drivers.

It is also interesting to note the stand of the judiciary system in relationship to the alcoholic offender's responsibility for other types of criminal conduct: assault, larceny, robbery, or murder. Presently the courts are not willing to accept drunkenness as a defense although they will accept insanity. The legal system stipulates that intoxication does not involve the type of rationality loss that insanity does. Therefore, they have ruled that alcoholism in no way justifies the offender's relief from criminal responsibility.

While the judiciary system does not acknowledge negligent drunkenness as a defense for crime, it does adhere to the principle that involuntary intoxication can be used as a defense against criminal charges. Too, many courts now are allowing a defense of drunkenness to indicate absence of the necessary mental state required for such crimes as first-degree murder, larceny, burglary, attempt to commit rape, and attempt to commit murder.

The President's Crime Commission has pointed out that often enforcement of penalties for public intoxication is selective and biased, with the number of arrests in a city related less to the amount of public drunkenness than to police policy. These questions and ambiguities are perhaps veering society toward the attitude that penalties sanctioned by the legal system are insufficient to deal with the problem of alcohol-related criminal offenses.

In a 1975 study conducted in Phoenix Ariz. of persons arrested for driving while under the influence, 37 percent of those arrested were identified as "high risk" problem drinkers. The researchers conducting the study concluded that "a large percentage of drunk drivers are valid clients both for the judicial-corrections system and for the alcoholism rehabilitation system. An adequate procedure for dealing with the problems of these clients would be one in which both systems can function together effectively to produce both a non-alcoholic person and a sober driver" (Sandler, et. al., 1975).

REFERENCES

Alcohol and Health. Report from the Secretary of Health, Education, and Welfare. New York: Charles Scribner's Sons, 1972.

Chafetz, M.E. (ed.). *Proceedings of the fourth annual alcoholism conference of the National Institute on Alcohol Abuse and Alcoholism.* Washington, D.C.: Department of Health, Education and Welfare Publishers, 1974.

Chafetz, M.E. and Demone, H.W. *Alcoholism and society.* New York: Oxford University Press, 1962.

Hayman, M. *Alcoholism: mechanism and management.* Springfield, Illinois: American lecture series publications, 1966.

Hutt, P.B. *Legal control of alcoholism: toward a public health concept.* 19. S.C.L. Rev. 305, 1967.

Kittrie, N.N *The right to be different.* Baltimore: Johns Hopkins Press, 1971.

Sandler, Irwin, et. al. "Drinking characteristics of DWI's screened as problem drinkers." *Alcohol Health and Research World.* Fall, 1975, 19-23.

Chapter X

INSTRUCTIONAL PLANNING

Education and training methods constantly change by responding to developments within society. Among the most recent changes in education have been the following: (1) a heightened awareness of minority populations within society and of their problems, and a growing commitment to do something about inequality; and (2) an increasing concern about the impact of change on the physical and social ecology, with special emphasis on the dehumanizing tendencies of a technological society.

A combination of social, technical, and educational developments may now have brought within reach the realization of objectives that long have been sought under frustrating circumstances. For years learning has been known to be both individual and goal-oriented. Yet goal-oriented individualized instruction has been largely unattainable in both schools and training programs. With new insights and skills in curriculum and materials preparation, and with impressive new technologies, however, whole new worlds of opportunity have emerged (Houston and Howsam, 1972).

Competency-based Instruction

The concept of competency-based instruction has emerged from the emphases of goal-orientation and individualization. Training goals or objectives can be made explicit and tailored for the trainee. The individual then can pursue learning activities and can develop performance skills or competencies in the process. When this approach is coupled with an appropriate management and delivery system, the accountability principle can be applied to all aspects of the instructional program. The word *competency* is defined as "adequacy for a task," or as "possession of required knowledge, skills, and abilities." Competency-based instruction is a simple, straightforward concept with the following central characteristics: (1) precise learning objectives — defined in behavioral and assessable terms — must be known to the trainee and trainer alike; (2) accountability — the trainer knows that he is expected to demonstrate the specified competencies to the required level and in the agreed-upon manner; and (3) personalization — each trainee has some choice in selection of the objectives and of learning activities. Individualization does not imply that all instruction is oriented toward independent activities. Special group instructional processes are also effective options.

Writing Clear Objectives

Learning objectives as outlined by Houston and Howsam in their book, *Competency-based teacher education*, are commonly classified according to one of the five kinds of criteria that may be applied to assessing performance: (1) *Cognitive objectives* — specify knowledge and intellectual abilities or skills to be demonstrated by the trainee; (2) *Performance objectives* — require the trainee to demonstrate an ability to actually perform some activity; (3) *Consequence objectives* — expressed in terms of the results of the learner's actions. In training programs, such objectives are expressed in terms of the accomplishments of the trainees under direction of the trainer; (4) *Affective objectives* — deal with attitudes, values, beliefs, and relationships; (5) *Exploratory objectives* — also called experience or expressive objectives, specify activities that hold promise for significant learning; they require the learner to experience the activities. All five of these kinds of objectives are used in competency-based training programs. Those employed at any time are chosen on the basis of the nature of the competencies required, the available assessment means, and other situational factors, The ultimate objective of the competency-based movement is the maximal employment of consequence objectives.

A number of issues concerning objectives are of importance to those seeking to implement a competency-based alcohol abuse training program for minorities. These issues involve such questions as the following:

> (1) Is it *desirable* to base a training program on objectives?

(2) Is it *possible or practical* to base a training program on objectives?

(3) Who should make the *decisions* about behaviors that trainees need?

(4) What *behaviors characterize* effective trainers?

(5) Should the objectives of various alcohol abuse training programs be standardized?

(6) Should *trainees* be held *accountable* for meeting the behavioral criteria specified by objectives?

Curriculum Design

The traditional curriculum imposes constants of training assignments and time requirements; the achievement of the trainee is the variable. In the competency-based curriculum the constant is trainee achievement, while variability of training, assignments, and time is permitted and even encouraged.

Traditional curricula have focused on subject matter, disregarding the variations among trainees and assuming or attempting to force a hypothetical homogeneity of trainees. The competency-based curriculum with its emphasis on shared objectives cannot be designed in abstraction or isolation, without regard for the intended learners as individuals. Competency-based curricula stress individual assessment, provision of alternative paths for individual trainees, and individual choice of goals.

The systematic approach to curriculum development is another basic concept in the framework of competency-based curriculum design. The number of variables in the process of preparing trainers is so great that a systematic design is needed to account properly for each factor, its relevance, its place in the sequence of training, and its production function. A systematic approach to curriculum development leads naturally to a self-renewing program. All inputs to the curriculum must be accounted for; these inputs are the available resources — human, financial, and environmental. The inputs are processed by the system to meet the specific goals, developed on the basis of assessed needs of the trainees.

The resulting output or product then can be evaluated against the defined criteria, yielding appropriate feedback information that is recycled as new input for processing by the system. This ongoing refinement of the training program prevents the system from becoming static.

Evaluation and Feedback

Clear, competency-based objectives permit more effective evaluation of both trainees and the program. The objectives of the traditional programs are so general that they provide little direction for instruction. Adequate evaluation is impossible. Competency-based programs, on the other hand, identify the objectives, the criteria, the performance indicators and the criterion levels so clearly for the trainee that he can assess for himself whether or not the objectives have been met.

The training program developer can compare the success in meeting the objectives of trainees completing various learning activities. He can examine energy output, resources required, and time needed to complete various program requirements through pre- and post-assessments. Because of the explicitness, a data-based feedback system leads to programmatic formative evaluation as described by Houston and Howsam (1972).

Module Construction

For the purpose of the alcohol abuse training program project, we will employ a unit of learning called a module. The instructional module includes a set of activities intended to facilitate the trainee's achievement of a specified objective or set of objectives. It is a relatively self-contained unit, designed for a specific purpose, and is part of two broader, more comprehensive instructional systems. The module used in this program focuses on limited objectives and can be completed in a short period of time, whereas the module employed in other training programs is broad in scope and requires a week or month to complete.

The modules will include five parts: (1) the *rationale* is a clear statement explaining the importance and relevance of the objectives to be achieved; (2) the *objectives* of the module are stated in criterion-referenced terms, specifying the considerations for successful completion; (3) a *pre-assessment* tests the trainee's competence in selected prerequisites and evaluates his present competence in meeting the objectives of the module. On the basis of this pre-assessment, the trainee may focus his efforts on the areas of greatest need; (4) the *enabling activities* specify several procedures for attaining the competence specified by the module objectives; and (5) the *post-assessment*, like the pre-assessment, measures competency in meeting the module objectives. The modules also include feedback mechanisms by which the trainees are informed of their performance and progress. Successful performance on a post-assessment signals completion of the module.

The modules used for the project are concerned with requirements in the areas of: communication; knowledge of alcohol use and alcoholism; evaluation and assessment; planning; referral; counseling and treatment relevant to minority populations. These general areas were adapted for the training program from a "Proposal on Standards" prepared for NIAA by the Roy Littlejohn Associates, Incorporated, 1974.

Module I — Communication

Rationale. This area is characterized by taking into consideration the multitude of communication situations to be found in serving the clients of specific minority populations. It is important for the individual to communicate both understanding and caring for each client from the minority populations in order to be effective.

Pre-assessments. To test the person on areas of communicating with persons from minority populations and to see if he understands the dialect from the different minority populations. This can be done with multiple choice items, true-false items, or standardized role interviews in which the trainee is rated on his responses. (See assortment of questions that might relate to Module I at end of chapter.)

Objectives.

(1) to communicate and understand accurately the dialects of the minority populations

(2) to speak, read, and write with proficiency

(3) to be able to establish communication readily

(4) to maintain records and write reports

(5) to communicate understanding, caring, and expertise to clients from minority populations in order that they may explore and better understand their problems, concerns, and needs

Enabling Activities.

(1) Demonstration by trainer of effective communication

(2) Demonstration by trainer concerning nonverbal behavior/body language

(3) Discussion — by trainees

(4) Role playing — breaking into small groups and practicing interpersonal communication skills

(5) Handouts — on interpersonal communication skills

(6) Readings — books, journal articles having to do with the art of communication or interpersonal communication, especially with the minority populations

(7) Audio-visual — programmed training material on the art of communication — found in libraries usually or slides on communication skills.

Post-assessments.

Can use the same questions as for pre-assessments. To see if there is a gain or change of score, you can use a different form related directly to the above objectives. This is up to the trainer. (There is an array of suggested questions at the end of this chapter.)

Module II — Knowledge of Alcohol Use and Alcohol in Relation to Minority Populations

Rationale. This area is concerned with imparting a basic knowledge of the effect of alcohol on human beings. After obtaining such knowlede concerning the effects of alcoholism, the trainee can become fully engaged in prevention programs or in counseling individuals and families with problems caused by the effect of alcohol.

Pre-assessments. To test the person on his knowledge of the effects of alcoholism in the following areas: physiological, psychological, sociocultural, and pharmacological concerning minority populations. (See questions at end of this chapter.)

Objectives. (Related to alcohol use and alcoholism within minority populations)

(1) to investigate the effects of alcohol on the human body

(2) to learn the relationship of blood alcohol levels and human behavior

(3) to be knowledgeable of the illness and recovery process

(4) to understand clearly the physiological mechanism of dependencies

(5) to investigate psychological dependencies and complications

(6) to understand the patterns of progression, recovery, and reconstruction

(7) to investigate the value and attitude systems related to alcohol, drinking patterns, and their development

(8) to learn of the family, subcultural, specific communities, spiritual, industrial, and legal ramifications

(9) to investigate alcohol as a chemical

Enabling Activities.

(1) Lectures by trainer on the effects of alcoholism from the: (a) physiological; (b) psychological; (c) socio-cultural; and (d) pharmacological points of view

(2) Presentation from anthropological approach on the characteristics and similarities of minority population in relation to the phenomenon of alcoholism

(3) Research materials such as books, periodicals, reports listed from Chapter V, "Resource Materials"

(4) Programmed material — having the trainee listen to cassette tapes from the National Institute of Alcohol Abuse and Alcoholism and the National Council on Alcoholism on the different effects of alcohol

(5) Films — showing films secured from national organizations having to do with the effects of alcoholism relevant to minority population

Post-Assessments. Use the pre-assessment form to see if there is a change or gain in score or construct an alternate form measuring directly the objectives listed. (See questions at end of chapter.)

Module III — Evaluation and Assessment

Rationale. This area is concerned with giving trainees the ability to assess the needs and problem states of the recipient of therapy.

Pre-Assessments. To test the person's knowledge of human growth and development, family dynamics, signs and symptoms of alcoholism within the minority population, and analytical skills. The test questions can be either multiple choice or true-false.

Objectives.

(1) to obtain knowledge of human growth and development including physical, cognitive, and personality development

(2) to obtain knowledge of family and group dynamics

(3) to investigate the early, middle, and late signs and symptoms of alcoholism and poly-drug abuse

(4) to investigate symptoms needing other medical-pyschological-social assessment

(5) to investigate family disfunctioning

(6) to assess stages of alcoholism found in clients

(7) to be knowledgeable of case history methodology

(8) to be able to recognize appropriate treatment modalities

(9) to be able to evaluate the client's progress

(10) to gain knowledge of goal-setting and problem-solving techniques.

Enabling Activities.

(1) Lecture by trainer on (a) human growth and development related to minority populations; (b) family dynamics; (c) signs and symptoms of alcoholism; and (d) analytical skills

(2) Handouts — list of books, periodicals, and reports. (See Chapter V for resource materials.)

(3) Films and video tapes — secured from NIAA for training purposes

(4) Visit — to mental health clinic to observe the development of a case history.

Post-Assessments. Use the pre-assessment form or an alternate form to measure the competencies and objectives outlined.

Module IV — Planning

Rationale. This area is concerned with having the trainees involve their clients in planning to assure healthy participation of individuals and families from the minority populations in the counseling-treatment process.

Pre-Assessments. To assess the skills of: sharing evaluation findings with the client; involving clients in the process of planning; informing clients of their legal rights; assisting clients in making arrangements to pay for counseling-treatment.

Objectives.

(1) To develop skills in sharing evaluation findings with the client and in working through client reactions or resistance to the evaluation

(2) To develop skills in involving clients in the process of planning for counseling and treatment

(3) To develop skills in informing clients of their legal rights regarding the acceptance and participation in a treatment or recovery program

(4) To develop skills in assisting clients in making arrangements to pay for counseling services

Enabling Activities

(1) Presentation by trainer — of the basic skills as stated in the section on objectives

(2) Discussion by trainees as to the effectiveness of skills presented

(3) Evaluation — role playing, with one trainee as the counselor and the other the client. Then switch roles. After role playing, then a discussion of what actually happened during the role playing

(4) Resource materials — found in Chapter V, materials and resources directly related to the module

Post-Assessments. To either give an alternate form to the pre-assessment form or to have a person play the client through a standardized role and rate the helper by audio or video tapes.

Module V — Referral

Rationale. This module is concerned with helping the individual trainee to recognize and utilize appropriate agencies to meet the specific needs of clients. Clients from minority populations have a multitude of needs that may require a multidisciplinary approach.

Pre-Assessments. To assess the trainee on specific outreach skills, knowledge of referral agencies at local, state, and national level, skills in making a referral, use of other related types of counseling and services not directly related to alcoholism for the families of the alcoholic, ability to provide follow-up with the referral agencies.

Objectives.

(1) To develop such outreach skills as recruiting clients and mobilizing community resources

(2) To have knowledge and maintain files of the different types or resources as to eligibility requirements, treatment philosophies, and admission and contact principles

(3) To develop the ability to contact and contract with other persons, agencies and groups, including those of different treatment philosophies than one's own

(4) To determine proper referral resouces

(5) To develop interpersonal skills in interpreting to the client the referral resource and its function in relationship to his problems.

(6) To develop the ability to assist individuals and families with alcohol-related problems with referral for other types of counseling and services — pastoral counseling, public assistance, and vocational rehabilitation counseling

(7) To develop the ability to follow up and provide advocacy to insure reponsiveness of service providers

Enabling Activities.

(1) Lecture — by trainer on the right and wrong way to develop a resource list and on developing relationships with other agencies

(2) Demonstration — of communicating with other agencies and interpreting an agency to the client

(3) Preparation — each trainee should prepare a list of agencies from the local, state, and national levels that work with alcohol abuse programs

(4) Resource materials — lists from both NIAAA and NCA on resources or referral agencies. (See Chapter V for agencies and their addresses.)

Post-Assessments. Ask the trainees to list the referral agencies that work with minority populations on the local, state, and national level. Also, have them retake the pre-assessment form to see if their score improved.

Module VI — Counseling and Treatment

This module is concerned with the skills and knowledge related to counseling and treatment processes. Counseling is thought of as not merely supportive of treatment, but as constituting a major portion of the treatment in changing the behavior of the client.

Pre-Assessment. To assess the trainee on specific techniques and skills of counseling from behavioral, transactional analysis, and Carkhuff's Human Relations Training models. To also include terms and techniques of the physiological or sociological theories.

Objectives.

(1) To test the trainee on the ability to establish a therapeutic relationship

(2) To obtain knowledge and the ability to use certain counseling techniques to: facilitate exploration of feelings and self-understanding, educate, and motivate the client

(3) To obtain knowledge of, or ability to locate and develop, basic informational support systems

(4) To develop basic counseling skills from behavioral, transactional analysis, and personality-trait theories

(5) To both define and practice the helping dimensions as presented in the Systematic Human Relations model by Carkhuff

(6) To develop the ability to participate in and coordinate a client's continuum of treatment and services

(7) To obtain knowledge of various in-patient and out-patient treatment processes

(8) To develop skills in managing the transitions along the continuum of treatment

(9) To be knowledgeable of long-range rehabilitative processes

(10) To be familiar with the physiological theories of alcoholism such as genetic, endocrine, genetrophic, and disease theories

(11) To be familiar with the sociological theories of alcoholism such as cultural transmission theories, symbolic interaction, and anomie theories

Enabling Activities.

(1) Presentation — of the basic skills and rationale of the behaviorist, transactional analysis, and personality and trait theory related to alcoholics from minority populations

(2) Presentation and discussion — of the helping dimensions as outlined by Carkhuff in The Systematic Human Relations Model

(3) Lectures — on the specific theories from both the physiological and sociological approaches to alcoholism

(4) Role Playing — of a counseling session with alcoholics from minority populations practicing both facilitative and problem-solving skills.

(5) Field visits — to mental health facility to observe various in-patient and out-patient treatment processes dealing directly with minority populations

(6) Discussion — as to long-range rehabilitative processes

(7) Resource materials — concerning the different theories found in books, periodicals, and even video tapes or films. This can be obtained from NIAAA or National Council on Alcoholism

Post-Assessments.

(1) Use pre-assessment form to observe any change or gain in individual trainee's score

(2) Construct alternate form measuring specific areas that are directly related to objectives

(3) Assessment of role playing where the trainee is the helper or counselor in a standard role interview

Effective Use of Audio-Visual Materials

The following factors are considered among the most important in the effective utilization of audio-visual media. First and perhaps most importantly, effective audio-visual material must meet the individual needs of the user and, therefore, the organization and presentation of an audio-visual aid must be trainee-centered. Second, the aid must yield a direct and purposeful experience. A concrete as opposed to an abstract concept is obviously more permanent and meaningful to an individual in a learning situation. Third, the presentation of a concept via audio-visual means should be directed toward a particular end. Fourth, the content material should be converted into behavioral objectives. An evaluation must be made as to what can be accomplished through the particular aid chosen, the feasibility of using the specified aid, and the steps devised to meet this objective. Finally, the audio-visual materials utilized should be organized in such a way as to provide for rapid accessibility and retrieval.

Recommendations for Alcohol Abuse Prevention Materials

Item 1. All new materials shall be independently pre-tested or evaluated and post-tested.

Item 2. All new materials shall be properly labeled to include:

Designated audience

Type of message or intended use (information, training, persuasion, etc.)

Date of production

Reproduction statement that admonishes private organizations to seek the advice of the sponsoring agency if any modifications in content or layout are planned

Item 3. The following kinds of messages have been found to be generally counterproductive, and as such, should be excluded from use in general information materials:

The use of alcohol X always causes condition Y.

The use of alcohol X never causes condition Y.

Alcohol is the only problem.

Alcohol abuse is exclusively a problem of the minorities.

Any message couched in terms which tend to scare the subject and make fear the main deterrent to future use.

We say, "You should not use certain types of alcohol."

Presenting only one treatment modality as "the Answer."

Stereotypes for interviews and settings: businessman in suit, young people in sandals, Black man as pusher, trash can alley, 42nd Street, Haight-Ashbury, etc.

Item 4. Material dealing with the following kinds of messages should be developed:

The effect of alcohol as a drug is a function of the dosage, the method of administration, the frequency of use, the individual and the environment.

The alcohol problem is complex. There are no easy answers. No two alcohol users are alike.

Society has an inconsistent position regarding the use of chemicals to alter an individual's mood. Some are legal while others are illegal.

Alcohol abuse is a social problem, not just a medical problem.

Young people need positive images rather than the reinforcement of existing stereotypes of dead-end addiction.

People can help to solve the alcohol abuse problem by promoting the following conditions: better communication with minority populations; an acceptance by others of the validity of alternative life styles; value structures in which immediate gratification is not at the top of the list.

Special films for minorities, with emphasis on decision-making, attitudes, and value clarification.

Array or Assortment of Questions for Pre- and Post-Tests

The following 137 questions can be used on either the pre- or post-assessments directly related to each module's objectives. The questions were taken from a study by Metcor Incorporated, a private health services management firm of Washington, D.C. under contract with the National Institute of Alcohol Abuse and Alcoholism, contract #74-0034. An answering key follows the questions at the end of this chapter.

MULTIPLE CHOICE

Please read each of the following statements carefully and then, from the different answers listed, choose those that you think are correct. Indicate your responses by marking (X) alongside the appropriate answer or answers. Please remember that for *some* questions there is only one correct answer while for other questions some or *all* of the answers may be correct.

1. Which of the following statements concerning alcohol are true?

a. Alcohol abusers shorten their life spans by 10-12 years.
b. The "skid row" alcoholic represents the greatest proportion of alcohol abusers
c. One in five persons report that someone close to them — most often a family member — has a problem with alcohol.
d. Since Prohibition, the proportion of drinkers in the United States has increased.
e. a, c, and d
f. All of the above
g. None of the above.

2. Which of the following agencies offer information and referral sources to the community:

a. Alcoholics Anonymous
b. National Council on Alcoholism
c. Center for Alcohol Studies at Rutgers University
d. Salvation Army/Volunteers of America
e. All of the above

3. Whether an individual drinks and how much he drinks may be influenced by:

a. Sex and age
b. Economic status
d. Education
d. Occupation
e. None of the above

4. The way to get over a hangover is:

a. Drink coffee
b. Start drinking again
c. Urinate frequently
d. All of the above

5. "Alcoholic blackouts" occur because:

a. The person passes out
b. The person drank the wrong kind of liquor
c. Alcohol affected the brain
d. The person is too old to drink
e. The body reacts strongly to too much alcohol

6. Antabuse is a chemical that:

a. Will cure alcoholism
b. Makes you sick if you drink after taking it
c. Keeps you from wanting a drink
d. All of the above

7. The counselor can tell if a person is alcoholic by asking him:

a. If he drinks in the morning
b. If he drinks alone
c. If his drinking affects his work
d. If he drinks every day
e. All of the above

8. Some things that are common experiences of most alcoholics are:

a. Sneaking drinks
b. Gulping drinks
c. Drinking every day
d. Denying the problem
e. Drinking alone

9. People become emotionally dependent on alcohol because:

a. The body needs it
b. They are weak people

c. Alcohol changes the way they feel
d. They like the way it tastes

10. It is difficult to get the alcoholic to stop drinking because:

a. Alcoholism is a disease and can't be treated successfully.
b. The alcoholic denies his problem.
c. He uses alcohol to deal with his negative feelings.
d. Family and friends keep him drinking.
e. All of the above.

11. An advantage of inpatient treatment for the alcoholic is:

a. It emphasizes the need for change.
b. It makes denial easier to deal with.
c. It gives him a rest from stress and frustration.
d. It makes medical help readily available.
e. All of the above.

12. A disadvantage of inpatient treatment for the alcoholic is:

a. That he uses it to escape from "real life"
b. That it places a burden on the family
c. That it creates additional financial worries
d. It is embarrassing for patient and family
e. All of the above

13. An advantage of outpatient therapy for the alcoholic is:

a. That he continues to work
b. That he cannot continue to deny his problem
c. that he must deal with problems daily
d. None of the above
e. All of the above

14. Group counseling is an effective treatment tool for alcoholics because:

a. It allows people with similar problems to discuss and help each other arrive at answers.
b. It lets the client know he is not alone with his problem.
c. The group can tell the client what the answer to his problem is.
d. It allows the client to test the reality of his ideas with others.

15. Marital counseling with the alcoholic and spouse is very helpful because:

a. The spouse doesn't know what the alcoholic is going through.
b. The alcoholic doesn't know how the spouse really feels.
c. Both are sick.
d. Both need to learn to talk effectively with each other about problems.
e. Alcoholism always creates problems for the spouse.

16. The Counselor should listen carefully to what the client is saying because:

a. This makes the client feel he is talking with someone who cares.
b. What the client doesn't talk about is important.
c. It gives the counselor time to think what his answer will be.
d. The counselor will need to clarify for the client what is being said.
e. Good feedback can *only* be given by the counselor on the basis of what the client says.

17. "Clarification" on the part of the counselor means:

a. Taking conflicting parts of the client's story, organizing them, and letting the client know what he (the client) has been trying to say
b. Making a distinction for the client between what he actually says and what he really means
c. Letting the client know what counseling is about

18. "Summarizing" on the part of the counselor means:

a. Listening to the client, pulling parts of the story together, and letting the client know what the problem is

b. Saying, "So far, this is what I've heard you saying to me . . . "

c. Saying, "So far, I haven't heard anything that makes me think you need counseling."

19. A "defense mechanism" is:

a. Something used by people to avoid letting other people know what is wrong with them

b. Something used by people to prevent them from finding out unpleasant truths about themselves.

c. Something the client can use with the counselor that will hinder progress of treatment

d. None of the above

e. All of the above

20. Alcoholic "denial":

a. Protects the client from facing his problems

b. In a lot of cases is not "denial" — it is lying

c. Hurts the progress of counseling

d. Should be dealt with by the counselor as early as possible

e. All of the above

21. Clients try to manipulate the counselor by:

a. Lying to him

b. Praising him

c. Giving him gifts

d. Telling him sad stories

e. Threatening to report him to his supervisor

22. Which of the following actions on the part of the counselor will hinder the progress of treatment?

a. Setting goals too high for the client

b. Feeling uneasy when counseling the client

c. Jumping to conclusions

d. Being too supportive of the client

e. All of the above

23. Some especially difficult problems to deal with when counseling alcoholics are:

a. Brain damage

b. Threats of suicide

c. Seductive behavior

d. Anxiety

24. The alcoholic's spouse:

a. Probably is part of the problem

b. Is as sick and as much in need of help as the alcoholic

c. Needs to be told to be more supportive and less critical of the alcoholic

d. Needs help in dealing with the feelings created by the alcoholic's behavior

e. All of the above

25. Children of alcoholics:

a. Usually are flexible and adjust to the situation without any bad feelings

b. Will probably become alcoholics themselves

c. Reject alcohol entirely when they are adults

d. Need help in dealing with their feelings about the situation

e. b and d

26. Group counseling is generally considered more effective than individual counseling with alcoholics because:

a. Alcoholics tend to become socially isolated.

b. Group breaks down the "I'm the only one with these kinds of problems and feelings."

c. They can hear others talk and realize they are not so bad off after all.

d. Group provides opportunity for peer feedback.

27. Some attitudes on the part of the client that hinder group therapy are:

a. "I'll listen, but I'll only talk to my counselor."

b. "If the group leader is not an ex-alcoholic, this group can't help me."

c. "If these people are all alcoholics, I can't possibly be one. I don't drink as much as they do."

d. "this group is very helpful but it's only part of what I need."
e. All of the above

28. The benefits of group counseling for the client are:

a. The group can give him the answers to his problem
b. The group can confront him and help break down the denial of the problems
e. the group can give him support and encouragement with his plans.
d. a and b
e. b and c

29. The group counselor should:

a. Not let one person dominate the group
b. Not let a group member put him on the defensive
c. Not let the group know what his ideas are
d. Let each group member know, before he enters group, what is expected and what he can expect in the group situation
e. All of the above

30. Which of the following statements concerning follow-up on referrals are true?

a. Follow-up makes sure that the client gets good treatment.
b. Follow-up makes sure client is satisfied with the agency.
c. Follow-up is necessary before the referral process is considered complete.
d. Good follow-up means not only contacting the agency but also the client himself.
e. All of the above
f. a, c, and d
g. None of the above

31. Which of the following community resources could be used as an alcoholism counselor?

a. Alcohol Detoxification Center
b. Emergency Room Service
c. Division of Social Security
d. Mental Health Center
e. a, b, and d
f. All of the above
g. None of the above

32. In referring an alcoholic to another helping agency or individual, the counselor should be aware that:

a. Many alcoholics do not keep referral appointments made.
b. That the alcoholic may try to "buy time" from the counselor — "I'll go two weeks from now but first I have to . . ."
c. That part of the referral process may be convincing the alcoholic client that he needs help and should get it now.
d. a and b
e. None of the above

33. Why would it be helpful for the client to have a physical examination as part of the evaluation process prior to out-patient therapy?

a. The individual may have physical problems caused by alcohol abuse.
b. All alcoholics have some physical damage due to alcohol abuse.
c. The client needs reassurance of his physical condition.
d. a and c
e. All of the above

34. Emotional dependence on alcohol occurs because:

a. alcohol is a drug that changes feelings
b. alcohol has come to be associated with relief from stress
c. dependent people become alcoholic if they drink
d. alcoholics have addictive personalities

35. Emotional dependency on alcohol is:

a. the same as physical dependency
b. the motivating force to start drinking again
c. the basis of the desire to drink when sober
d. none of the above

36. Alcohol:

a. is a drug

b. is a stimulant

c. kills brain cells

d. builds blood

e. all of the above

37. Alcoholism in the United States is:

a. a major health problem

b. caused by numerous social factors

c. an expense to industry

d. all of the above

e. none of the above

38. For the counselor, which area of the body affected by alcohol is most important:

a. heart

b. blood

c. brain

d. liver

39. Which of the following are dangerous for the alcoholic during withdrawal:

a. irritability

b. pneumonia

c. seizures

d. fever

40. Why is coercion helpful in keeping the alcoholic in an in-patient clinic:

a. He wants relief from the crisis situation

b. He is not motivated for recovery

c. He is not realistic about his problem

d. all of the above

41. Alcoholics Anonymous is:

a. a professional organization

b. a church-affiliated organization

c. a laymen's fellowship

d. a program founded in 1935

e. anti-professional help for the alcoholic

42. An evaluation interview:

a. Should be no longer than 30 minutes

b. Should be recorded in the client's file

c. Should always come before the social history interview

d. Is a significant factor in developing the treatment plan for the client

e. All of the above

43. A social history interview:

a. Should never involve the children

b. Should be evaluated very carefully

c. May produce as much denial as the evaluation interview with the client

d. None of the above

e. All of the above

44. The "significant other" interview:

a. Should never be known about by the client

b. Is a clarification technique

c. Done by letter, is less reliable than if done in other ways

d. Should also involve asking the person for help with the client

e. Is relatively unimportant as far as the treatment is concerned

45. The advantages to out-patient counseling are:

a. The counselor can deal with the client when his problems are immediate

b. The counselor finds it much easier to work with the client because hs is not confined in a hospital

c. That it is not as expensive as in-patient care

d. That you can "get down to basics" much more quickly

e. All of the above

46. In out-patient counseling:

a. Discourage "trial by fire tests" by the client

b. Only check on his current problems every time you see the client

c. Be careful how intense any confrontation is

d. It is good for the client to set high goals for himself, even if he cannot reach them

e. All of the above

47. Signs that a client may be "building up to a drunk" are:
   - a. Extremely critical
   - b. Don't care attitude
   - c. Asking questions about social drinking
   - d. Looking depressed
   - e. Saying "I've got it made"
   - f. Smiling a lot and denying problems
   - g. All of the above

48. "Staying busy" can, for the client, be:
   - a. A way of avoiding dealing with emotional problems
   - b. Eventually his excuse for drinking again
   - c. If appropriate, very helpful to the client
   - d. All of the above
   - e. None of the above

49. The role of Antabuse in treatment should be explained to the client as:
   - a. The psychological crutch he will need to stop drinking
   - b. The cure for his alcoholism
   - c. Something which, if taken with the right attitude, can help him to deal with the drinking and give him some time and freedom to work on other problems
   - d. Something that may make him sleepy and, if it does, he should see a doctor
   - e. All of the above

TRUE FALSE

PLEASE MARK X IN COLUMN UNDER T [TRUE] OR F [FALSE]

T F *QUESTIONS*

50. Alcohol enlarges the liver.
51. When an individual drinks alcohol he urinates frequently, causing low body fluids.
52. Alcohol enlarges arteries and helps the flow of blood.
53. A hangover, in part, is caused by a "swollen brain."

T F *QUESTIONS*

54. Alcohol dissolves fats in the body and cleans out the system.
55. The acute phase of withdrawal from alcohol can result in death.
56. Seizures from alcohol withdrawal occur only within the first week.
57. If a client has a seizure the best thing to do is to get him to lie flat on his back and rest.
58. Anxiety and depression never occur together.
59. Social drinkers never drink alone.
60. It is important to find out why a person drinks if you are to help him.
61. A definition of alcoholism, to be of any use in counseling, must involve how often a person drinks as one of the criteria.
62. A person cannot become alcoholic if he only drinks beer.
63. "Loss of control" means alcohol's interference with the person's job.
64. The desire to take a drink in a familiar situation that usually involves drinking is due to a conditioned response.
65. Body tolerance means being able to drink without getting sick.
66. Alcoholic blackout means passing out.
67. You can't tell if somebody is drinking if he uses vodka.
68. Antabuse is a substance used in some hospitals to cure alcoholism.
69. Social influences are relatively unimportant when looking at the cause of alcoholism.
70. A religious background will stop people from becoming alcoholic.
71. Alcohol is basically a spiritual problem.
72. It is not the job of the counselor to deal with the client's religious ideas.
73. A man's occupation has little to do with his alcoholism.
74. An advantage of in-patient treatment is that the client gets a rest,, away from the stress of everyday living.

T F *QUESTIONS*

75. A disadvantage of in-patient treatment is that the counselor has a greater opportunity to confuse the client with too much material.

76. Group therapy is one of the most effective forms of therapy with alcoholics.

77. In-patient care eliminates the need for out-patient care.

78. Alcohol abuse costs industry $15 billion a year.

79. Alcoholics have a strong resistance to illness because alcohol kills germs.

80. Drinking while shoveling snow is good for the person because it kills germs.

81. Emotionally dependent people generally are understanding and tolerant.

82. Only recovered alcoholics can help an alcoholic recover.

83. Alcoholics Anonymous does not believe in the alcoholic ever telling other people he is an alcoholic.

84. An alcoholism counselor is a specialist in counseling alcoholics but also possesses basic counseling skills effective with any client.

85. It is not important for the counselor to know the effects of alcohol on the body.

86. Basic social worker knowledge and skills are not part of the counselor's role.

87. To be effective the alcoholism counselor should have had a problem with alcohol himself.

88. The alcoholism counselor should never tell the client about his own problems.

89. The alcoholism counselor should never tell friends about a client's problems.

90. The ultimate goal of counseling is to help the client feel better about himself.

91. Alcoholics have a tendency to feel they are "worse off" than other people.

92. Emotionally dependent people are overly anxious to act on the insight they have.

93. The only goal of the alcoholism counselor is to stop the alcoholic from drinking.

T F *QUESTIONS*

94. A major goal in counseling the alcoholic is to get the client to assume personal responsibility for his drinking.

95. Listening carefully to the client means writing down what the client says so you won't forget.

96. Non-verbal skills means letting the client do the talking.

97. Re-statement is also clarification.

98. Summarization is also clarification.

99. It is important for the counselor to distinguish between what the client says and what he means.

100. Support for the client is always good.

101. An evaluation interview is designed to find out what the family thinks is wrong with the client.

102. Non-verbal skills do not play an important role in the evaluation interview.

103. The purpose of the evaluation interview is for the counselor to begin to get a clear understanding of the client's situation.

104. The treatment plan for the client is based solely on the findings of the evaluation interview.

105. The social history interview can function as a check on the validity of the client's story.

106. The social history interview is usually an attempt to find out what other treatment programs know about the client.

107. In evaluating the social history interview, the person giving the information should always be believed in preference to the client.

108. A social history interview should give you significant information about the client's past.

109. A social history interview should provide important information for the

T F QUESTIONS

development of the treatment plan for the client.

110. Contacting "significant others" in the client's life is only necessary if you don't have a social history.

111. The "significant others" let you know how people outside the client and the family view the situation.

112. All contacting of "significant others" should be by personal interview in the counselor's office.

113. An interview with the client and his employer should never take place — this is a breach of confidentiality.

114. Information gained from "significant others" should not be recorded in the client's file.

115. The write-up of a social history interview should not contain everything that was learned about the client.

116. Information from the evaluation interview, social history interview, and "significant others" interview is all you need to know about any client.

117. Involving the client in planning his treatment program helps the client see that the counselor is being fair and unbiased.

118. It is necessary for the counselor to get the client to make an emotional investment in his own recovery.

119. The counselor should help the client work through his reactions to the treatment plan.

120. The counselor should leave out any aspect of the treatment plan that upsets the client.

121. Both counselor and client have their individual responsibilities in terms of carrying out the treatment plan.

122. The counselor and the agency he works for should be able to meet all the needs of the alcoholic.

123. It is important for the counselor and the helping agency to coordinate their efforts.

T F QUESTIONS

124. The counselor should be aware of the type of treatment offered by a helping agency.

125. The police department is not a community resource.

126. Once the referral is made there is no need to follow up on the client.

127. Patients committed to a psychiatric facility lose their civil rights.

128. Mental health laws are easy to understand and interpret.

129. Alcohol addiction legally is considered a disease.

130. Alcohol addiction legally is considered a mental illness.

131. The counselor should never tell the client he is requesting that the family have him committed.

132. Diversion is a program where the first offender is directed away from the criminal justice system.

133. Criminal Court Clinic is the place where offenders are sent for physical examination.

134. Community-based correctional facilities are welcomed by communities because of their desire to help the offender.

135. Referral of alcoholics to a helping agency is a specialty.

136. The referring counselor should leave the decision to get help up to the client.

137. The referring counselor should make "getting help" as difficult as possible for the client to test his motivation.

ANSWER KEY

1. e
2. e
3. a,b,c,d
4. b, c
5. c,e
6. b
7. c
8. a,b,d,e
9. c
10. b,c,d
11. e
12. e
13. a,c
14. a,b,d
15. a,b,d,e
16. a,b,d
17. a
18. b
19. e
20. e
21. all
22. e
23. a,b,c,d
24. a,d
25. d
26. a,b,d
27. e
29. a,b,d
30. e
31. f
32. a,b,c
33. e
34. a,b
35. b,c
36. a,c
37. d

38. c
39. c
40. d
41. c,d
42. b,d
43. b,c
44. b,c
45. a,c
45. a,c
47. g
48. d
49. d
50. T
51. T
52. F
54. F
55. F
56. F
57. T
58. F
59. F
60. F
61. T
62. T
63. F
64. F
65. F
66. F
67. F
68. F
69. F
70. F
71. F
72. F
73. F
74. F
75. F
76. T
77. F
78. T
79. F
80. F
81. F
82. F
83. F
84. T
85. F
86. F
87. F
88. T
89. T
90. F
91. T
92. F
93. F
94. T
95. F
96. F
97. T
98. T
99 T
100. F
101. F
102. F
103. T
104. F
105. T
106. F
107. F
108. T
109. T
110. F
111. T
112. F
113. F
114. F
115. T
116. F
117. T
118. T
119. T
120. F
121. T
122. F
123. T
124. T
125. T
126. F
127. F
128. F
129. F
130. T
131. F
132. F
133. F
134. F
135. T
136. F
137. F

REFERENCES

Callahan, R.E. *Education and the cult of efficiency.* Chicago, Illinois: University of Chicago Press, 1962.

Chisholm, M. Effective utilization of media. In P.S. Grove and E.B. Clement (Eds.). *Bibliographic control of media.* Chicago: American Library Association, 1972.

Cooper, J.M. and Weber, W. *A competency-based systems approach to teacher education.* Berkeley, California: McCutchan Publishing Corporation, 1972.

Guilford, J.P. *The nature of human intelligence.* New York: McGraw-Hill, 1967.

Houston, R.W. and Howsan, R.B. *Competency-based teacher education.* Chicago, Illinois: Science Research Associates, Inc., 1972.

McDonald, F.J. and Allen, D.W. *Training effects of feedback and modeling procedures on teacher performance.* Palo Alto, California: Stanford University, 1967.

Roy Littlejohn Associates, Inc. *Proposed national standards for alcoholism counselors.* Prepared for the National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland 20852, Contract No: ADM-41-74-0010.

Chapter XI

FUNDING FOR ALCOHOL PROGRAMS

Since 1960, alcoholism as a disease has received significant public recognition and a new understanding as a major health problem. Public and private agencies have begun to realize that they have a direct responsibility to deal with alcoholism from both a programmatic and financial standpoint. Since no one resource can effectively deal with multifaceted problems of alcohol, the local community must seek various funding sources in the establishment and development of truly comprehensive, coordinated community-based alcoholism prevention, control, and treatment programs (Vereb, 1974). This chapter is by no means intended to be an indepth study of *all* funding agencies related to alcoholism, but represents a broad view of some of the more recognizable funding resources.

Local Community

In reality, this is where the application for funds should begin, but, at times, the division of research at the State office after a study may develop a community-based program which will be reviewed by the community before any application is submitted. Most of the funding sources have their own forms, but this is the type of information that funding resources are seeking:

(1) Title of proposal
(2) Project Director: name, position, mailing address, phone
(3) Department, Service, Agency: Levels of organization, address
(4) Project Period: From thru
(5) Total Funding Requested
(6)Performance sites: Location for service delivery
(7) Name, title of official signing for applicant organization
(8) Project narrative:
    (a) Baseline Information: Rationale/ Need — Documentation
    (b) Purposes and Objectives
    (c) Target Population
    (d) Training Facilities and Procedures
    (e) Anticipated Results: Assumption and Hypotheses
    (f) Assessment-Evaluation
(9) Budget Summary
    (a) Personnel (Include Fringe Benefits)
    (b) Consultant Costs
    (c) Travel
    (d) Equipment (Purchased or rental)
    (e) Space (Purchased or rental)
    (f) Supplies
    (g) Communications
    (h) Other — state specifically
(10) Biographical Sketches: Professional Personnel

Once the form is completed, the agency or institution might approach either the United Way or a local foundation. There are many national foundations that have local chapters in the geographical region that might be funding resources.

United Way

The United Way has a long history of funding for many local programs. In a lot of instances, it is an excellent source of funding when trying to secure local match monies, funds for small demonstration projects, and revenue to supplement other grants. There are certain specific steps the agency or institution must follow when applying for funds from the United Way. The method of application is established by each respective United Way agency and prospective applicants should contact the executive director (Vereb, 1974).

Foundations

There are two basic kinds of foundation grants: (1) General purpose — may be used for general operating expenses but are difficult to obtain; and (2) Special projects — easier to obtain but are related to specific need and concerns. In approaching a foundation, it is important to be as knowledgeable as possible of the foundation and how its general purpose and special interest relate directly to your project proposal. To find out more about the foundations, refer to the Foundation Director, Annual Report or Information Form (990-A) required by the Internal Revenue Service. Good resources as recommended by Vereb (1974) are: (1) *How to Get Your Fair Share of Foundation Grants;* and (2) *Successful Foundation Presentations* by Joseph Dermer. Some of the foundations which have supported alcohol abuse-alcoholism programs are: Adult Laboratories, Amoco Foundation, Coca-Cola U.S.A., Ford Foundation, Robert Wood Johnson Foundation, Metropolitan Life Insurance, RCA Corporation, United States Steel, The Kroger Company, and The McClellan Foundation.

Revenue Sharing

General revenue sharing to cities and counties throughout the country has provided funds for a variety of purposes but due to the discretionary nature of these funds, little has been utilized for alcoholism services. Special revenue sharing, soon to become a reality under the Better Communities Act, may be a far more promising resource for funding. Although still discretionary in nature, the intent of these funds is more appropriate to the community-based services which alcoholism programs are attempting to provide. Whereas revenue sharing funds are not plentiful enough to fund a comprehensive program, a component of such a program may be financed through this source. General revenue funds remain "federal" in nature and thus cannot be utilized to match other federal funds. There is a strong possibility, however, that the special revenue funds may lose their "federal" status and thus be utilized in such a manner.

The method of application for revenue sharing funds is established by the respective unit of government disbursing such funds. An applicant should contact the city or county commission in which a program operates to determine the appropriate application process (Vereb, 1974).

State Alcoholism Agencies [SSA]

It is important to remember when developing a project to work very closely with the Single State Agencies both in investigating and making the application for a grant on alcoholism. The single state agency can be very supportive and helpful in both directing and supplying research information and data needed for the grant. Also, they can aid in coordinating efforts at the state level with other state agencies such as State Departments of Education, Welfare, Corrections, Division of Vocational Rehabilitation, and state law enforcement planning agencies. Some of the areas in which state alcoholism authorities can be of help are: (1) community assistance grants; (2) survey, field test, and demonstration grants; (3) occupational grants; (4) *training grants*; (5) prevention grants; (6) research grants; and (7) *special projects grants dealing with minority populations.*

For a mailing and phone list of the state alcoholism authorities, write or call:

National Clearinghouse for Alcohol
Information
Box 2345
Rockville, MD 20853
Phone: (301) 948-4450

Regional Offices

The regional offices of NIAAA coordinate and plan programs on a regional level. The following is a list of NIAAA offices by region:

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM REGIONAL OFFICE

[Address: Associate Regional Health Director for Mental Health

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)
John F. Kennedy Federal Building
Boston, Massachusetts 02203
Phone: Code 617, 223-6824

Region II (New Jersey, New York, Puerto Rico, Virgin Islands)
26 Federal Plaza
New York, New York 10007

Region III (Delaware, Maryland, Pennsylvania, Virginia, Washington, D.C., West Virginia)
P.O. Box 12900
Philadelphia, Pennsylvania 18108
Phone: Code 215, 597-4505

Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
50 Seventh Street N.E., Room 423
Atlanta, Georgia 30323
Phone: 404, 526-5231

Region V (Indiana, Illinois, Minnesota, Ohio, Wisconsin, Michigan)
300 South Wacker Drive
Chicago, Illinois 60606
Phone: Code 312, 353-1700

Region VI (Arkansas, Louisana, New Mexico, Oklahoma, Texas)
1114 Commerce Street
Dallas, Texas 75202
Phone: Code 214, 749-3426

Region VII (Iowa, Kansas, Missouri, Nebraska)
601 East 12th Street
Kansas City, Missouri 64106
Phone: Code 816-374-5291

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)
Federal Office Building
Room 9017, 1961 Stout Street
Denver, Colorado 80202
Phone: Code 303, 837-3177

Region IX (Arizona, California, Hawaii, Nevada, Guam, American Samoa, Wake Island)
Federal Office Building
50 Fulton Street
San Francisco, California 94102
Phone: Code 415, 556-2215

Region X (Alaska, Idaho, Oregon, Washington)
1321 Second Avenue
Seattle, Washington 98101
Phone: Code 206, 442-0524

AREA ALCOHOL EDUCATION AND TRAINING PROGRAMS, INCORPORATED

The Area Alcohol Education and Training Programs serve a composite of states under a grant award from the National Institute on Alcohol Abuse and Alcoholism, Division of Resource Development. The programs provide education and training for the participants from their designated areas and investigate existing programs to be further disseminated throughout their areas concerning the enhancement of manpower resources and community awareness in the alcohol field. Education and training grants are available and the reader must contact the following Area Alcohol Education Training Programs as to application procedures. Complementary to the funding role of the area training programs are investigations in the areas of needs assessment, information collection, and dissemination.

The following is a roster of the Area Alcohol Education and Training Programs in the United States. Listed additionally are the states under the regions, directors, mailing address, and phone numbers.

WESTERN AREA ALCOHOL EDUCATION TRAINING PROGRAM, INC.

Dallas Reed, Ph.D., Director
1755 East Plumb Lane, Suite 260
Reno, Nevada, 89502
(702) 786-3610

SERVES:

Alaska
Arizona
California
Colorado
Hawaii
Idaho
Montana
Nevada
North Dakota
Oregon
South Dakota
Utah
Washington
Wyoming

EASTERN AREA ALCOHOL EDUCATION AND TRAINING PROGRAM, INC.

Edward Alderette, Director
776-B Juniper St., NE
Atlanta, Georgia 30308
(404) 875-7196

SERVES:

Connecticut
Delaware
District of Columbia
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Puerto Rico
Rhode Island
Vermont
Virgin Islands
Virginia
West Virginia

SOUTHERN AREA ALCOHOL EDUCATION AND TRAINING PROGRAM, INC.

Charles Sapp, Director
P.O. Box 512
Bloomfield, Connecticut 06002
(203) 243-8326

SERVES:

Alabama
Arkansas
Florida
Georgia
Kentucky
Louisiana
Mississippi
New Mexico
North Carolina
Oklahoma
South Carolina
Tennessee
Texas

MIDWEST AREA ALCOHOL EDUCATION AND TRAINING PROGRAM, INC.

William Butynski, Ph.D., Director
180 North Michigan Avenue, Suite 1031
Chicago, Illinois 60601
(312) 782-0073

SERVES:

Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
Ohio
Wisconsin

NIAAA NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

(This section is adapted from a chapter on "Guide to Community Alcohol Programs: Funding" by Martha Vereb for the State of Florida, Bureau of Alcoholic Rehabilitation.)

Under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Public Law 91-616, federal grants are authorized for local communities to develop and expand treatment and rehabilitation services for the prevention and treatment of alcoholism.

NIAAA limits all grants to a maximum of $300,000 per year up to three years. Support is available under this legislation for a variety of purposes related to the improvement or expansion of community alcoholism services including:

1. *COMMUNITY ASSISTANCE GRANTS:*

a. Comprehensive Alcoholism Service System Grant:

Supports to stimulate the growth and development of a broad range of services to meet the needs of alcoholic persons in a coordinated and continuous manner. The term "Comprehensive Services" is defined by the Institute as a network of assistance that makes available all services meeting the range of needs exhibited by the person in trouble with alcohol and those individuals who make up his milieu such as family members, employees, and friends.

b. Survey, Field Test, and Demonstration Grants:

(1) Supports survey of need, resources, existing programs, as well as the feasibility of developing new or additional programs, elements of service, facilities for treatment or prevention of alcoholism.

(2) Field trials to test ideas, organization, delivery systems and treatment methods before applying them on a broad scale.

(3) Demonstration of new, innovative programs and methods not previously used; adapt old methods to a new geographic area; demonstrate to community methods it can use to initiate, extend or improve its delivery system.

2. *OCCUPATIONAL GRANTS:*

Supports effort to develop and implement activity designed to meet needs of employed persons with problems related to their use of alcohol (Employee Assistance Programs).

3. *TRAINING GRANTS:*

Provides support (1) to increase the effectiveness of existing alcoholism manpower of all types, (2) to make alcohol education and staff development a built-in component of service, training, and research programs in all settings dealing with the alcohol problem, (3) to develop manpower to meet the immediate and urgent needs for successful implementation of the NIAAA's programs, (4) to establish, expand and improve training programs in alcoholism.

4. *STATE ASSISTANCE GRANTS:*

Formula grants to enable each state to develop and implement a comprehensive and coordinated statewide alcoholism program. The STATE PLAN with detailed guidelines will provide for activities related to planning, establishing, maintaining, coordinating and evaluating projects for more effective prevention, treatment and rehabilitation programs. Plan will be reviewed at least annually with no state receiving less than $200,000.

5. *PREVENTION GRANTS:*

Supports the development of effective and practical methods of preventing the abuse and misuse of alcoholic beverages and the testing and evaluating of the effectiveness of these methods.

6. *RESEARCH GRANTS:*

Encourages and supports scientifically important, methodologically sound, basic and applied research related to studies in the areas of alcoholism. Public or private non-profit instutitions or individuals are eligible to establish, expand, or improve research activities in the alcohol abuse prevention, treatment and rehabilitation areas.

7. *SPECIAL PROJECTS GRANTS:*

Supports programs for the treatment and rehabilitation of alcoholics which will demonstrate new or relatively effective or efficient methods of delivery of service. Similar to community assistance grants except the target population is a sub-group of the community rather than the community as a whole. Any public or private non-profit agency, organization or institution is eligible. Guidelines are available for Women, Indian, Public Inebriates, Drinking Driver, Poverty, Spanish American, offenders in the criminal system, and Blacks. Special projects *are not limited* to these categories for which guidelines have been developed. It is suggested that the Demonstration guidelines be followed for other groups.

Considerations When Applying

It is of fundamental importance in the consideration of an application that financial support from other sources be obtained from the beginning of the program and be increased during subsequent years of the program with assurance of program continuation at the time of termination of federal support.

Priority for approval and funding will be determined in large part by the amount of funds and other support to be made available from all sources to the applicant for the purpose of supporting the program proposed in the application. Support from other sources should constitute no less than 10 percent of the total project costs for the first year, and an increase in this percentage share of the total costs should be projected for the duration of the grant period for which federal support is sought. These other sources of support include, but are not limited to, client fees, third party payments (insurance, Medicare, Medicaid, local welfare contributions), state funds designated for alcoholism, general rehabilitation or vocational rehabilitation, funds from municipal or county governments and contributions from private agencies, such as United Fund, foundations and private corporations.

(For an update on funding resources and processes, write the Alcohol and Drug Problems Association of North America, 1101 15th Street, N.W., Washington, D.C. 20005, for their report: *Funding of Alcohol and Drug Programs: A Report of the Funding Task Force.*)

REFERENCES

Alcohol and Drug Problems Association of North America. *Funding of alcohol and drug programs: a report on the funding task force.* 1101 15th Street, N.W.: Washington, D.C., 1975.

National Institute on Alcohol Abuse and Alcoholism: *Alcohol and alcoholism: problems, programs, and progress.* Washington: U.S. Government Printing Office, 1972.

National Institute on Alcohol Abuse and Alcoholism. Proceedings of the joint conference on alcoholism, College Park, Maryland, February, 1972.

Vereb, M. Guide to community alcohol programs: funding. In S.G. Clark (ed.), *Guide to community alcohol programs.* Tallahassee, Florida: Bureau of Alcoholic Rehabilitation, 1974.